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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01613

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie-rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie-rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>				d. STREET ADDRESS <b>604 Old Stage Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Ruben</b> Middle <b>M.</b> Last <b>Alspaw</b>				4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 1, 1927</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEVISION</b>		11. BIRTHPLACE (State or foreign country) <b>COLUMBIA, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUBEN MONTGOMERY ALSPAW</b>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 2ND WORLD WAR</b>		16. SOCIAL SECURITY NO. <b>493-28-8875</b>		17. INFORMANT <b>W.S. WHEELER, 1111 CAHEKON RD ALEX. VA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>driver in auto-auto collision</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:20</b> p.m. <b>2 23 1967</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Anne Arundel Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		M.D. <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>2/24/67</b>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3-1-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>W. of Md. Nat. School</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Newell</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 1 1951

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01614

01611

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>715 Genessee St.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>ARNOLD</b>				4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1895</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sign Painting</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN H. ARNOLD</b>				14. MOTHER'S MAIDEN NAME <b>JOHANNA L. EMMERICH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>ANNE A. ARNOLD</b> Address <b>#2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> <b>Chromia</b> DUE TO (b) <b>Chronic nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>we</del> ) attended the deceased from <b>Feb. 22, 1967</b> to <b>Feb. 22, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Feb. 22, 1967</b> , and that death occurred at <b>2:55 AM</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Richard I. Hochman, MD.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, MD</b>				22d. ADDRESS <b>1001 Gannaway St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>BURIAL</b>		<b>2-25-67</b>		<b>Hillcrest</b>		<b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR <b>John M. Lofors</b>				ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Ann Arnold

Bayland

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715 Lawrence St.

Ann Arnold General Hospital

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JOHANN L. EMMEICH

John H. Arnold

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Ann A. Arnold

no

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Feb. 25

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JOHANN L. EMMEICH

JOHANN L. EMMEICH

Ann Arnold

Hillcrest

285-67

Feb. 25 1935

Chicago, Ill.

Chicago, Ill.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01615

01612

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Mayo (Edgewater)</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt 1 Box 313 D</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mayo (Edgewater)</u> <span style="float: right;">02-1</span> d. STREET ADDRESS <u>Rt 1 Box 313 D Edgewater</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>SADIE</u> <u>FRANCES</u> <u>BAIL</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>11</u> Year <u>1967</u>		<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct. 28, 1890</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>never worked</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mayo, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Willeminia Behlke</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214-05-2425D</u>		<b>17. INFORMANT</b> Address <u>same as #2</u> <u>Mrs. Paul D. Spitnale-daughter - above</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gen. Carcinomatosis</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Ca of sigmoid</u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan</u> <u>1955</u> , to <u>2/11/67</u> , 19 <u>  </u> , that (I) ( <u>see</u> ) last saw the deceased alive on <u>2/10/67</u> , 19 <u>  </u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>S. Borssuck, M.D.,</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/13/67</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type)						<b>22d. ADDRESS</b> <u>Amos Garrett Blvd., Annapolis, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Feb. 14, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mayo Methodist Church</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Mayo, Anne Arundel, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping Funeral Home</u> - Annapolis, Md.						<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 16 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01616

01613

1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXXXXXXXXXXXXXXXX Ferndale</u>	
c. LENGTH OF STAY IN lb <u>25 yr -</u>		d. STREET ADDRESS <u>106 First Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 - 1st Ave - 8 - Ferndale</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Buckley Bamberger</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse &amp; Saleslady Dept. Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph W. Bamberger</u>		14. MOTHER'S MAIDEN NAME <u>Ja. Poole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>312-185095A</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Diabetes -</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 yr -</u> <u>7 yr -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>50</u> , to <u>3/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles L. Ball Jr.</u> M.D.		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball Jr.</u>		22d. ADDRESS <u>Linthicum, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 13, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>	23d. LOCATION (City, town or county) (State) <u>Howard Co., Elkridge, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Engene B. Fleming</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Singleton Funeral Home</u> <u>Glen Burnie, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

01617

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 3 & 14 Film G 386

2/28/67 jml

CERTIFICATE OF DEATH

01614

1. PLACE OF DEATH a. COUNTY <b>A. A.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>MD.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Md.</b> d. STREET ADDRESS <b>713 Carolyn Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Raymond Benzing</b> First Middle Last		4. DATE OF DEATH <b>Feb. 17, 1967</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/06</b>
9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hanline Bros.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Bensinger</b>		14. MOTHER'S MAIDEN NAME <b>Kate Meekin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>215-05-9063</b>	
17. INFORMANT <b>Glen Burnie, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 yrs</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1966</b> , to <b>Feb 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/18</b> 1967, and that death occurred at <b>6 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>JOSEPH TALER</b>		22b. DATE SIGNED <b>2/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>		22d. ADDRESS <b>Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/20/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1967</b>	
ADDRESS <b>4107 Wilkens Ave. 21229</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01618

## CERTIFICATE OF DEATH

01615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL - and give nearest town) <b>RURAL - GLEN BURNIE</b>		c. LENGTH OF STAY IN lb <b>13 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL GENERAL HOSPITAL</b>		e. STREET ADDRESS <b>232 GRANDVIEW RD. LONG POINT</b>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>BERGER</b> Last <b>BERGER</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 7, 1907</b>
9. AGE (In years last birthday) yrs. <b>59</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. of SANTIATION</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian Berger</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Downing</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-5779</b>	
17. INFORMANT <b>Helen Berger</b>		Address <b>232 Grandview Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Lung</b> (c) <b>Lung</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 9, 1967</b> to <b>February 10, 1967</b> that (I) (we) last saw the deceased alive on <b>February 9, 1967</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. B. RAMIREZ</b>		22b. DATE SIGNED <b>2/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. B. RAMIREZ</b>		22d. ADDRESS <b>3527 ANNAPOLIS RD Balto 27</b> <b>1672 NORTH BOURNE RD Balto 12</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>7225 Eastern Ave Balto. Md</b>	
24. FUNERAL DIRECTOR <b>Frederick D. Miller Inc</b>		25a. REC'D BY REGISTRAR <b>St FEB 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01015

ESTIMATE OF LOSS

01015

21

Estimated Loss

Estimated Loss

21-1-1948 (1948-1-21)

21-1-1948 (1948-1-21)

21-1-1948 (1948-1-21)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01619

CERTIFICATE OF DEATH

01616

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Laurel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>36 yrs. 2 mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irene Berry</b>		4. DATE OF DEATH <b>February 7, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-94</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>67</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Children's Center Hospital, Laurel, Md.</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3255</b> IMMEDIATE CAUSE (a) <b>Intestinal obstruction with marked gastric dilation and diffused gastric hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mental retardation</b> (c) <b>2 days</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1, 1930</b> , to <b>Feb. 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 7, 1967</b> , and that death occurred at <b>10:20 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>George T. Economos</b>		22b. DATE SIGNED <b>2/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE T. ECONOMOS, M. D.</b>		22d. ADDRESS <b>Children's Center Hospital, Laurel, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/10/67</b>		23b. DATE THEREOF <b>Children's Center</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Laurel</b>		23d. LOCATION (City or Town) (County) (State) <b>A. A. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert Donaldson Laurel Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01620					01617				
1. PLACE OF DEATH e. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>NORTH DAKOTA</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JESSUP</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SE MINOT</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US HIGHWAY 32 NEAR JESSUP, MD</b>					d. STREET ADDRESS <b>108 19TH STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FABIAN</b> First <b>NMI</b> Middle <b>BLACK JR.</b> Last					4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>4</b> Year <b>19 67</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 APRIL 1943</b>		9. AGE (In years last birthday) <b>23</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US ARMY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>RUGLY, ND</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>FABIAN BLACK SR.</b>					14. MOTHER'S MAIDEN NAME <b>LENA KRUTZ</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>MAR 66-4 FEB 67 502-48-0067</b>		17. INFORMANT <b>FABIAN BLACK SR(F)</b> Address <b>108 19TH STREET SE MINOT, ND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar Skull Fracture, Laceration(R) Lung and Liver</b> DUE TO <b>Liver</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Liver</b> (c)									INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>1:30</b> e.m. <b>Feb 4</b> 1967			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt # 32</b>		20f. (City or town) (County) (State) <b>Near Jessup (Anne Arundel) Md.</b>		
21. I certify that <del>the deceased died</del> the deceased <del>was</del> <b>DOA</b> <del>on</del> <b>Feb 4</b> 1967, <del>at</del> <b>1:30</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Capt Felix A. Conte</i>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4 February 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>FELIX A. CONTE, CPT, MC</b>					22d. ADDRESS <b>KIMBROUGH AH, FT GEO G MEADE, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>Feb. 9, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSEHILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MINOT, NORTH DAKOTA</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>					25a. REC'D BY REGISTRAR <b>DATE FEB 8 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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41-10

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF DECEASED	
10. SIGNATURE OF WITNESSES		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK		15. SIGNATURE OF NOTARY	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF JURY	
19. SIGNATURE OF GRAND JURY		20. SIGNATURE OF DISTRICT ATTORNEY		21. SIGNATURE OF COUNTY CLERK	
22. SIGNATURE OF COUNTY SHERIFF		23. SIGNATURE OF COUNTY DEPUTY SHERIFF		24. SIGNATURE OF COUNTY JURY	
25. SIGNATURE OF COUNTY GRAND JURY		26. SIGNATURE OF COUNTY DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY CLERK	
28. SIGNATURE OF COUNTY SHERIFF		29. SIGNATURE OF COUNTY DEPUTY SHERIFF		30. SIGNATURE OF COUNTY JURY	
31. SIGNATURE OF COUNTY GRAND JURY		32. SIGNATURE OF COUNTY DISTRICT ATTORNEY		33. SIGNATURE OF COUNTY CLERK	
34. SIGNATURE OF COUNTY SHERIFF		35. SIGNATURE OF COUNTY DEPUTY SHERIFF		36. SIGNATURE OF COUNTY JURY	
37. SIGNATURE OF COUNTY GRAND JURY		38. SIGNATURE OF COUNTY DISTRICT ATTORNEY		39. SIGNATURE OF COUNTY CLERK	
40. SIGNATURE OF COUNTY SHERIFF		41. SIGNATURE OF COUNTY DEPUTY SHERIFF		42. SIGNATURE OF COUNTY JURY	
43. SIGNATURE OF COUNTY GRAND JURY		44. SIGNATURE OF COUNTY DISTRICT ATTORNEY		45. SIGNATURE OF COUNTY CLERK	
46. SIGNATURE OF COUNTY SHERIFF		47. SIGNATURE OF COUNTY DEPUTY SHERIFF		48. SIGNATURE OF COUNTY JURY	
49. SIGNATURE OF COUNTY GRAND JURY		50. SIGNATURE OF COUNTY DISTRICT ATTORNEY		51. SIGNATURE OF COUNTY CLERK	
52. SIGNATURE OF COUNTY SHERIFF		53. SIGNATURE OF COUNTY DEPUTY SHERIFF		54. SIGNATURE OF COUNTY JURY	
55. SIGNATURE OF COUNTY GRAND JURY		56. SIGNATURE OF COUNTY DISTRICT ATTORNEY		57. SIGNATURE OF COUNTY CLERK	
58. SIGNATURE OF COUNTY SHERIFF		59. SIGNATURE OF COUNTY DEPUTY SHERIFF		60. SIGNATURE OF COUNTY JURY	
61. SIGNATURE OF COUNTY GRAND JURY		62. SIGNATURE OF COUNTY DISTRICT ATTORNEY		63. SIGNATURE OF COUNTY CLERK	
64. SIGNATURE OF COUNTY SHERIFF		65. SIGNATURE OF COUNTY DEPUTY SHERIFF		66. SIGNATURE OF COUNTY JURY	
67. SIGNATURE OF COUNTY GRAND JURY		68. SIGNATURE OF COUNTY DISTRICT ATTORNEY		69. SIGNATURE OF COUNTY CLERK	
70. SIGNATURE OF COUNTY SHERIFF		71. SIGNATURE OF COUNTY DEPUTY SHERIFF		72. SIGNATURE OF COUNTY JURY	
73. SIGNATURE OF COUNTY GRAND JURY		74. SIGNATURE OF COUNTY DISTRICT ATTORNEY		75. SIGNATURE OF COUNTY CLERK	
76. SIGNATURE OF COUNTY SHERIFF		77. SIGNATURE OF COUNTY DEPUTY SHERIFF		78. SIGNATURE OF COUNTY JURY	
79. SIGNATURE OF COUNTY GRAND JURY		80. SIGNATURE OF COUNTY DISTRICT ATTORNEY		81. SIGNATURE OF COUNTY CLERK	
82. SIGNATURE OF COUNTY SHERIFF		83. SIGNATURE OF COUNTY DEPUTY SHERIFF		84. SIGNATURE OF COUNTY JURY	
85. SIGNATURE OF COUNTY GRAND JURY		86. SIGNATURE OF COUNTY DISTRICT ATTORNEY		87. SIGNATURE OF COUNTY CLERK	
88. SIGNATURE OF COUNTY SHERIFF		89. SIGNATURE OF COUNTY DEPUTY SHERIFF		90. SIGNATURE OF COUNTY JURY	
91. SIGNATURE OF COUNTY GRAND JURY		92. SIGNATURE OF COUNTY DISTRICT ATTORNEY		93. SIGNATURE OF COUNTY CLERK	
94. SIGNATURE OF COUNTY SHERIFF		95. SIGNATURE OF COUNTY DEPUTY SHERIFF		96. SIGNATURE OF COUNTY JURY	
97. SIGNATURE OF COUNTY GRAND JURY		98. SIGNATURE OF COUNTY DISTRICT ATTORNEY		99. SIGNATURE OF COUNTY CLERK	
100. SIGNATURE OF COUNTY SHERIFF		101. SIGNATURE OF COUNTY DEPUTY SHERIFF		102. SIGNATURE OF COUNTY JURY	

Signature of Deceased



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**01621**

**CERTIFICATE OF DEATH**

**01618**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. *Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY in 1b <i>6 weeks</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis Nursing and Convalescent Home</i>		d. STREET ADDRESS (last) <i>Box 264, Rt 2, Pasadena, Ind</i>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>E.</i> Last <i>BOESSER</i>		4. DATE OF DEATH Month <i>2</i> Day <i>6</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-26-79</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>87</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>BOESSER</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-10-3802</i>	
17. INFORMANT <i>Roger T. Bollman</i> Address <i>Box 264, Pasadena, Ind</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left lower lobe Pneumonia</i> DUE TO <i>4/221</i> (b) <i>Congestive heart failure</i> DUE TO <i>Art. scler. cardio. vas. disease</i> (c) <i>Art. scler. cardio. vas. disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>years</i> <i>years?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus; cysto-pyelitis; senility</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>DEC. 15</i> , 19 <i>66</i> , to <i>Feb. 6</i> , 19 <i>67</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>Feb. 5</i> , 19 <i>67</i> , and that death occurred at <i>9:20 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter F. Verkouw</i>		22b. DATE SIGNED <i>2-6-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>PETER F. VERKOUW</i>		22d. ADDRESS <i>1407 FOREST DR. ANNAPOLIS, Ind.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>2/9/1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MORELAND MEMORIAL</i>	23d. LOCATION (City or Town) (County) (State) <i>BALTO MARYLAND</i>
24. FUNERAL DIRECTOR <i>WEBER FUNERAL HOME 5311 EDMONDSON AVE.</i>		25a. REC'D BY REGISTRAR <i>DATE FEB 8 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

01218

STATE OF DEATH

1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN lb <b>7 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				d. STREET ADDRESS <b>309 Third Ave. S. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>309 Third Ave. S. W.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Douglas</b>						4. DATE OF DEATH Month <b>Feb.</b> Day <b>23.</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>26 Aug. 1888</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegrapher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. RR</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Charles County, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Bowen</b>						14. MOTHER'S MAIDEN NAME <b>Virginia Kohler</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Alice Cowan Bowen, same as 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Standstill</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1960</b> to <b>Feb 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>2-22-1967</b> , and that death occurred at <b>2:30</b> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Benjamin Berdamm</b>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>Benjamin Berdamm, M.D.</b>						22d. ADDRESS <b>5010 Ritchie Highway, Baltimore 25, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>27 Feb. 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kirkley Funeral Home, Glen Burnie, Md.</b>						25a. REC'D BY REGISTRAR <b>DATE FEB 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01623

01620

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Hazell Brooks</i>		4. DATE OF DEATH Month <i>2</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-25-1891</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Watson</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Bladder</i> <i>1810</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Diabetes mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>66</i> , to <i>Feb-28</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Feb-28</i> , 19 <i>67</i> , and that death occurred at <i>2 P.M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Willard F. Smith MD</i>		22b. DATE SIGNED <i>3/3/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Willard F. Smith, MD</i>		22d. ADDRESS <i>Shady Side, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>MAR 6 1967</i>	

01639

01639

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

*[Faint handwritten notes and markings at the bottom of the page, including what appears to be a signature and some dates or numbers.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
016224					01621				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Anne Arundel County MARYLAND					a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Box 237, Elkridge 27, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital					d. STREET ADDRESS Hospital Ave Glen Burnie, Md.				
3. NAME OF DECEASED (Type or print) First Middle Last Frank M. Buchanan					4. DATE OF DEATH Month Day Year Feb. 14 1967				
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-24		9. AGE (In years last birthday) 42 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Foreman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank M. Buchanan					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Lorraine Buchanan-Box 237, Elkridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>September</u> , 1965, to <u>Feb. 14</u> , 1967, that (I) (we) last saw the deceased alive on <u>February 14</u> , 1967, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>E. Roderick Shipley</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>February 14, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley</u>					22d. ADDRESS <u>529 Camp Meade Rd, Linthicum Hts Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION (City, town or county) (State) Dorsey Road Howard County, Md.			
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave. 21229					25a. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01625

CERTIFICATE OF DEATH

01622

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>5955 Pinewood Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy BUNN</b>				4. DATE OF DEATH Month Day Year <b>February 26 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 26, 1967</b>		9. AGE (In years last birthday) yrs. <b>26</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Doyet E. Bunn</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>nonen</b>		17. INFORMANT <b>Doyet E. Bunn same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>7735</b> IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO (b) <b>Placental insufficiency</b> DUE TO (c) <b>Placental anomaly</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>5 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>9:15 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Joseph C. Sheehan</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Joseph C. Sheehan M. D.</b>				22d. ADDRESS <b>208 West Street, Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis, A.A. Md.</b>			
24. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> <b>Hopping Funeral Home</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01626						01623					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			A. A. Co			a. STATE			b. COUNTY		
			MARYLAND			M.D.			A.A. Co		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Inglewood Manor						Severna Park - 21146 02-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Mellersville Md						827 Cottonwood Drive			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			Month Day Year		
Lela B. Burkhardt						2-13-67			19		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept 23, 1886		80 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				House				Baltimore Md		U.S.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Henry J. Beck						Elizabeth Weaner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						B. H. Burkhardt		827 Cottonwood Dr 21146			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Toxicity & General debility											
4500											
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Secondary to Gen Asst.											
(c) 8											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work							
21. I certify that (I) (this hospital) attended the deceased from 1964, 19 to 1967, 19, that (I) (we) last saw the deceased alive on 2-8-67, 19, and that death occurred at 9:59 AM, from the causes and on the date stated above.											
22a. SIGNATURE								22b. DATE SIGNED			
Robert R. HAHN								2-13-67			
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS			
Robert R. HAHN								P.O. Box 73 Severna Park			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial				2-16-1967		Mendonville Cemetery		Elkridge - Howard Co - Md			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Edward P. McPherson				301 Frederick Rd - 28		DATE FEB 15 1967		Charles Judge			

01023

01023

James Park - 214  
841 Chestnut Street

Fortune, N.Y.  
Eighty Nine

A. A. [illegible] 841 Chestnut Street

Long 3 [illegible]

James A. [illegible] 841 Chestnut Street  
[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01627

01624

1. PLACE OF DEATH e. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE</b>		c. LENGTH OF STAY IN 1b <b>45 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>			d. STREET ADDRESS <b>St. STEVENS ROAD Rt. #1 Box #77</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>THOMAS EDWARD CAMPBELL</b>			4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1967</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 Dec 1899</b>		9. AGE (In years last birthday) <b>88 6/7</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Serviceman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Omar, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Thomas Campbell</b>		
14. MOTHER'S MAIDEN NAME <b>Matilda C. Laposki</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>1918-1948</b>		
16. SOCIAL SECURITY NO. <b>219-28-0757</b>			17. INFORMANT (son-in-law) Address <b>Thomas D. Hope, Cecil Ave, Millersville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. _____ p.m. _____ <b>19</b>	20d. INJURY OCCURRED While _____ Not While _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <del>10</del> (this hospital) attended the deceased from <b>12 Feb 1967</b> to <b>13 Feb 1967</b> , that <del>(s)</del> (we) last saw the deceased alive on <b>13 Feb 1967</b> , and that death occurred at <b>8:40 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Burton A. Johnson, MD</b>			22b. DATE <b>13 Feb 67</b>		22c. PHYSICIAN'S NAME (Type) <b>BURTON A. JOHNSON, MC, CPT</b>
22d. ADDRESS <b>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 15, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of the Field</b>	23d. LOCATION (City, town or county) (State) <b>Millersville, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Eugene B. Fleming</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		
25b. REGISTRAR'S SIGNATURE <b>Glen Burnie, Md.</b>			DATE <b>FEB 16 1967</b>		

45210

5230

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**01628**

**CERTIFICATE OF DEATH**

**01625**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARDOUR</u>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARDOUR</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALDEN LANE</u>				d. STREET ADDRESS <u>ALDEN LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ANNA</u> Middle <u>MARIE</u> Last <u>CARTER</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>13</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>L. PETER CARLSON</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINA JENSEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ELIZABETH C. TATE</u> Address <u>#2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery insufficiency + sclerosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Feb.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> P.M. from causes and on the date stated above.									
22a. SIGNATURE <u>John Hederman</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN HEDERMAN</u>						22d. ADDRESS <u>FOREST DR. ANNAPOLIS, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.H. MD.</u>		
24. FUNERAL DIRECTOR <u>John M. &amp; Sons Annapolis, Md</u>						25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5310

2320

21 Form 386 3-6- Maryland STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01629

01626

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE</b>			
				d. STREET ADDRESS <b>7905-B JENNINGS COURT</b>			
3. NAME OF DECEASED (Type or print) <b>KIRBY DOUGLAS CASE</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>20</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 NOV 1958</b>		9. AGE (In years last birthday) <b>8</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GULFPORT, MISS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CALVIN CASE, JR.</b>				14. MOTHER'S MAIDEN NAME <b>SHIRLEY A. RICHARDSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT (father) Address <b>Calvin Case, Jr. 7905-B Jennings Ct, FGM, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GUN SHOT WOUND OF CHEST</b> <b>9190</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Patient shot in chest</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>4:20</b> p.m. Month, Day, Year <b>20 Feb 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House</b>		20f. (City or town) (County) (State) <b>Ft Geo G Meade Anne Arundel Md.</b>	
21. I certify that (1) (this hospital) attended the deceased from <b>18 Feb 1967</b> to <b>20 Feb 1967</b> , and that death occurred at <b>4:20 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Harold T. Becher</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>20 FEB 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HAROLD T. BECHER, CPT, MC</b>				22d. ADDRESS <b>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Feb. 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT GROVE CEMETERY,</b>		23d. LOCATION (City, town or county) (State) <b>BROOKHAVEN, MISSISSIPPI, LINCOLN CO</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Harold S. Wade, 550 Wash. Blvd, Laurel, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 24 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

013310

013310

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, including what appears to be a list of names and dates.]

[Illegible text continues, appearing to be a detailed report or memorandum.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01630				CERTIFICATE OF DEATH				01627			
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hunter's Harbor</i>				c. LENGTH OF STAY IN 1b <i>2 1/2 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Paradise, Md.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none 1416 Peace Drive</i>						d. STREET ADDRESS <i>Hunter's Harbor 1416 Peace Dr.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James Leo Chance</i>						4. DATE OF DEATH <i>February 1 1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 17, 1915</i>		9. AGE (in years last birthday) <i>51 yrs.</i>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lithographer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Printing</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Chance</i>						14. MOTHER'S MAIDEN NAME <i>Bertha Gary</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes WW II</i>				16. SOCIAL SECURITY NO. <i>217-09-0541</i>		17. INFORMANT <i>Mrs. James Leo Chance, Paradise, Md.</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the urinary bladder</i> 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1965</i> , to <i>Feb. 1, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan. 30, 1967</i> , and that death occurred at <i>7 A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>R.M. McLaughlin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/1/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>						22d. ADDRESS <i>3708 Mountain Rd. Paradise, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>2-3-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethesda National</i>				23d. LOCATION (City, town or county) (State) <i>Bethesda Md.</i>			
24. FUNERAL DIRECTOR <i>Robert S. Bannard, Severna Park, Md.</i>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>			
						DATE <i>FEB 3 1967</i>					

01001

01001

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01631

01628

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Seven</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NOR 16. ARUNDEL - Gen.</u>		d. STREET ADDRESS <u>Box 193 - Burns Crossing Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>V</u> Last <u>Chase</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15 1886</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Bethel, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Campbell</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-46-2963</u>	
17. INFORMANT <u>Melvin L. Chase - Same as 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sen. Shk. heart Chest</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shk. infarct from Shk. wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1:50</u> a.m. <u>2/2</u> p.m. <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>A.A.CO. MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type)		22. DATE SIGNED <u>2/2/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-6-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Bethel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Fort Meade A.A.Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert R. Singleton</u> Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE <u>FEB 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01638

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01632

CERTIFICATE OF DEATH

01629

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL CO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> c. LENGTH OF STAY IN 1b <u>//////</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. CO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>#104 Balto. &amp; Annapolis Blvd</u> N/W e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ALBERT</u> Middle <u>FRANK</u> Last <u>CLAUSS</u>			<b>4. DATE OF DEATH</b> Month <u>FEB.</u> Day <u>8th</u> Year <u>19 67</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-15-98</u>		<b>9. AGE</b> (In years birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		<b>10b. KIND OF BUSINESS OR</b> <u>CLAUSS CLOTHING STORE</u> <u>GLEN BURNIE</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Glen Burnie, Md.</u>			
<b>13. FATHER'S NAME</b> <u>William H.S. Clauss</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara B. Blaustimer</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-32-1859</u>		<b>17. INFORMANT</b> Address <u>Mrs. Viola G. Clauss (wife) Same as #2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town) (County) (State)</b> _____							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1963</u> <b>to</b> <u>Feb</u> , 1967, that (I) (we) last saw the deceased alive on <u>Jan</u> 1967, and that death occurred at <u>7:30 P.M.</u> from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Hilary T. O'Herlihy</u> M.D.				<b>22b. DATE SIGNED</b> <u>2-8-67</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Hilary T. O'Herlihy M.D.</u>				<b>22d. ADDRESS</b> <u>5 Central Ave. Glen Burnie, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 11, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Memorial Pk.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Richard V. Singleton</u> <u>Glen Burnie, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 14 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**01633**

**CERTIFICATE OF DEATH**

**01630**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02-1</b> <b>Glen Burnie 21061</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>105 M. St.</b>			
3. NAME OF DECEASED (Type or print) First <del>XXXXXXXXXX</del> Middle <b>JEANNETTE</b> Last <b>COHN</b>				4. DATE OF DEATH <b>February 16 19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1885</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Oays Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>Joseph Oppenheimer</b>				14. MOTHER'S MAIDEN NAME <b>Juliette Marmelstein</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Mr. Rudolph Cohn, 8 Oak Lane, S. W. Glen Burnie</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma, Malignant</b> <b>2002</b> DUE TO <b>Type?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>1 1/2 yr.</b> DUE TO (c) <b>1 1/2 yr.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Oay, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-14-1967</b> to <b>2-16-1967</b> , that (I) (we) last saw the deceased alive on <b>February 16, 1967</b> , and that death occurred at <b>11:55 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Frank M. Shuping</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK SHUPING</b>				22d. ADDRESS <b>ANNAPOLIS MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Har Sinai (old)</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Young</b>	

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Handwritten notes and signatures, including a large signature in the center and various smaller entries and stamps.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01634

01634

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>12 Maryland Ave.,</b>		
3. NAME OF DECEASED (Type or print) <b>James Patrick CONNOLLY</b>			4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1902</b>		9. AGE (In years) <b>64</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - newspaperman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>John T. Connolly</b>			14. MOTHER'S MAIDEN NAME <b>Catherine V. McDermott</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>213-03-2952</b>		17. INFORMANT <b>Mrs. Audrey Connolly</b> Address <b>same address as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma of hypercalcemia</b> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary rib metastasis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) (County) (State)		21. I certify that (I) <del>this hospital</del> attended the deceased from <b>Jan 20</b> , 19 <b>67</b> , to <b>Feb. 8</b> , 19 <b>67</b> that (I) <del>was</del> last saw the deceased alive on <b>Feb. 8</b> , 19 <b>67</b> , and that death occurred at <b>10:00 AM</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>General Church</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>General Church</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/10/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Williamport, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Tishner &amp; Sons</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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[Name] [Address] [City] [State] [Zip]

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01635

## CERTIFICATE OF DEATH

01632

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u> d. STREET ADDRESS <u>1164 Easport Terrance</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) # <u>34590</u> <u>John W. Cooper</u> First Middle Last S. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/11/1885</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>17</u> Year <u>1967</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Peter Cooper</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>214-03-6993</u> 17. INFORMANT <u>Hospital Records</u> Address _____					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Dehydration</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Cerebral Arteriosclerosis - Hypostatic pneumonia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20. MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that (I) (this hospital) attended the deceased from <u>2/11/1967</u> , to <u>2/17/1967</u> , that (I) (we) last saw the deceased alive on <u>2/17/1967</u> , and that death occurred at <u>12:40M</u> , from causes and on the date stated above. 22a. SIGNATURE <u>Lionel McHenry Mapp</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u> 22d. ADDRESS <u>Crownsville State Hospital, Maryland</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/20/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u> 23d. LOCATION (City or Town) <u>Glen Burnie, Maryland</u> (County) _____ (State) _____ 24. FUNERAL DIRECTOR <u>Singleton Funeral Home/Glen Burnie, Md.</u> 25a. REC'D BY REGISTRAR <u>Robert Kwan</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>FEB 20 1967</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01633

DEATH OF DEATH

01632

RECEIVED FOR THE ATTORNEY GENERAL  
OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY, N. Y.  
JAN 10 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01636

CERTIFICATE OF DEATH

01633

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>401 Old Annapolis Road</b>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN FRANKLIN CRISP</b> First Middle Last		4. DATE OF DEATH <b>FEBRUARY 24</b> Month Day Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Crisp</b>		14. MOTHER'S MAIDEN NAME <b>Marguerite Broughon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Virginia Crisp</b> Address <b>401 Old Annapolis Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>1621</b> DUE TO <b>Bronchogenic carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <b>1966</b> , to <b>Feb</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>Jan</b> , 19 <b>67</b> , and that death occurred at <b>6 A-M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Aidan E. Walsh</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>AIDAN E. WALSH</b>		22d. ADDRESS <b>715 N. CHARLES</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-28-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b> ADDRESS <b>1901-07 Eastern Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE - B 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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Harvard

Harvard

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Old South

Old South

July 19, 1900

White

Baldwin, Maryland

Baldwin

Maryland

Maryland

Mrs. Virginia Oriskany

10

Baltimore County, Maryland

Oct. 1900

8-28-1900

Postal

Little & Carter Inc. 1901-02

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01638						01635					
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severn</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor Nursing Home</u>						d. STREET ADDRESS <u>39 Danza Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Edward D. Cronin</u>						4. DATE OF DEATH <u>Feb. 25, 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 11, 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown Cronin</u>						14. MOTHER'S MAIDEN NAME <u>Bridget Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>5400</u>		17. INFORMANT <u>Mrs. Richard Bahr</u>				Address <u>39 Danza Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Gastrointestinal hemorrhage</u> DUE TO <u>peptic ulcer of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fever</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Congestive heart failure - Atherosclerosis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>66</u> to <u>2/25</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2/21</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Edm Smith</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/25/67</u>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2 28 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Mc Cully</u>						ADDRESS <u>130 E. Fort Ave</u>		25a. REC'D BY REGISTRAR <u>FEB 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

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FOR STATE HEALTH DEPT.

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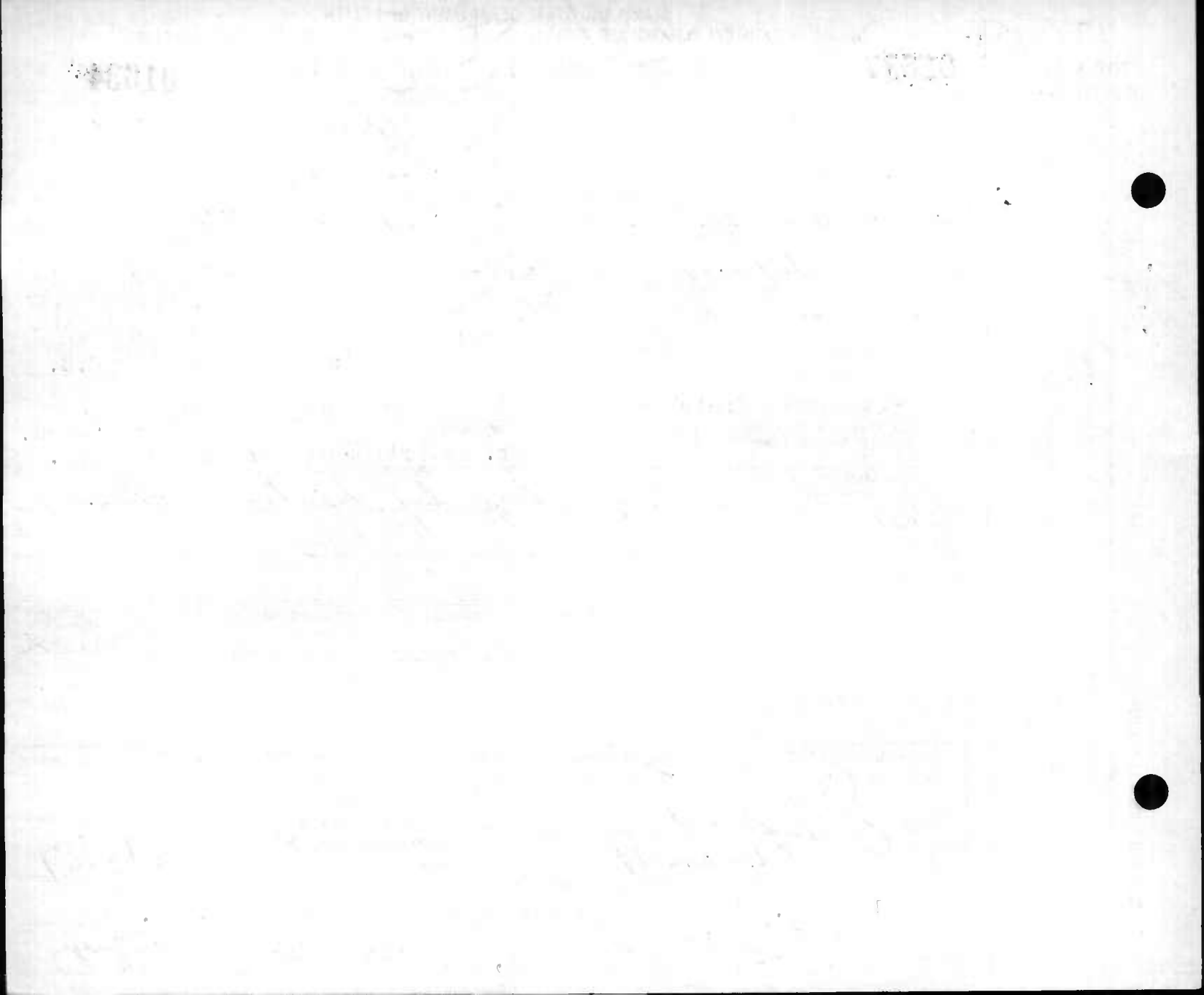
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01639

CERTIFICATE OF DEATH

01636

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u> <u>02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel County Hospital</u>			d. STREET ADDRESS <u>Four Rivers Farm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Daly</u>			4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1909</u>	9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder &amp; Developer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Orleans, Louisiana</u>	
13. FATHER'S NAME <u>Unknown</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Dorothy M. Daly</u> Address <u>Four Rivers Farm, Davidsonville, Maryland</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>3/26, 1967</u> , that (I) (we) last saw the deceased alive on <u>12</u> <u>1966</u> , and that death occurred at <u>7:22 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Richard I. Hochman</u>			22b. DATE SIGNED <u>2/26/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, MD</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>
24. FUNERAL DIRECTOR <u>Glenn Carter</u>			23d. LOCATION (City or Town) <u>Prince Georges Co. Md.</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

95210

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01640

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01637

1. PLACE OF DEATH a. COUNTY <u>AA.CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA.CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wentz Creek, Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.M. - Anne Arundel General</u>		d. STREET ADDRESS <u>Wentz Creek Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles W. Davis</u>		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-14</u>
9. AGE (In years lost birthday) yrs. <u>52</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self - emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Margaret L. Prince</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 - 07 - 6413</u>	
17. INFORMANT <u>Mrs. Loretta Davis, same as 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gun shot - wound - chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflated shot gun wound chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p.m. <u>2/28</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>AA.CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>2/28/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2 March 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Essex, Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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180101

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01641

CERTIFICATE OF DEATH

01638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>				c. LENGTH OF STAY IN lb <u>11 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Shadyside</u>			
3. NAME OF DECEASED (Type or print) <u>PRYNSE</u> First <u>XAVIER</u> Middle <u>DAVIS</u> Last				4. DATE OF DEATH <u>February 16</u> 19 <u>67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-94</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frnt &amp; Private</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St Louis Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 244343A</u>		17. INFORMANT <u>MRS Caryl E. Bittle, Shadyside Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>62</u> , to <u>Feb 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec</u> 19 <u>66</u> , and that death occurred at <u>8:30 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Willard F. Smith</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u>				22d. ADDRESS <u>Shady Side, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 20 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg P.L. Md.</u>	
24. FUNERAL DIRECTOR <u>Bernard Hardesty Belterville Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>gcharle</u>	

STATE OF TEXAS  
COUNTY OF DALLAS  
I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

25310

RECEIVED

25310

*[Faint, illegible handwritten text, likely a deed or legal document, covering the majority of the page.]*

*[Faint, illegible text on the right margin, possibly a recording or filing stamp.]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01642

CERTIFICATE OF DEATH

01639

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN lb <b>1 mo. 15 da.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shady Side</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nebraska</b> Middle <b>(none)</b> Last <b>DENNIS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward Dennis</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Sorrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>21846332</b>	
17. INFORMANT <b>Edward Dennis Shady Side</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia &amp; double pneumonia emboli</b> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ASCVD, aortic atherosclerosis, congested heart failure</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>did not</del> attended the deceased from _____, 19____, to <b>Feb. 19, 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>Feb. 19</b> 19 <b>67</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>R. Brien</b>		22b. DATE SIGNED <b>2/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Brien</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-23-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>		23d. LOCATION (City or Town) (County) (State) <b>Shady Side Md</b>	
24. FUNERAL DIRECTOR <b>William Reese</b>		25a. REC'D BY REGISTRAR <b>B 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01638

STATEMENT OF DEBIT

01638

Anne Arundel

Maryland

Anne Arundel

Shady Side

1 mo. 12 da.

Arundel

Anne Arundel General Hospital

67

19

February

DEBIT

(name)

Arundel

24

Aug. 12, 1895

Weto

Weto

U.S.

Maryland

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Feb. 12, 07

3:00 PM

AX

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Feb. 12

RECEIVED

151 Cathedral St., Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01643

CERTIFICATE OF DEATH

01640

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>112 South St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>(none)</b> Last <b>DILLARD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1892</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>A.A.Co Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>William Dillard</b>		14. MOTHER'S MAIDEN NAME <b>Nealie Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No *****</b>		16. SOCIAL SECURITY NO. <b>216-18-5259</b>	
17. INFORMANT <b>Helen Chase</b>		Address <b>22 Cornhill St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro - Vascular Accident</b> <b>592X</b> DUE TO <b>Hypertensive Ancho Cerebral Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stroke</b> DUE TO <b>Chronic Renal Disease</b> (c) <b>Stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <b>physician</b> attended the deceased from <b>1-6-67</b> , 19 <b>Feb. 1</b> , 1967, that (I) <b>last</b> saw the deceased alive on <b>Feb. 1</b> , 1967, and that death occurred at <b>1:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. T. Allen, M.D.</b>		22b. DATE SIGNED <b>2-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen, M.D.</b>		22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-4-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A.Co Md</b>
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111</b>		ADDRESS <b>Annapolis, Md</b>	
25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5420

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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form 1 or form 2

doi:10.1017/S002229240000199

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Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: the control group and the experimental group. The control group was divided into two subgroups: the control group and the control group. The experimental group was divided into two subgroups: the experimental group and the experimental group.

11. 11. 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
01644					01641										
1. PLACE OF DEATH a. COUNTY <u>A-A-Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u> c. LENGTH OF STAY IN 1b <u>10 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RED 2 Box 188 Ritchie Hwy</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A-A-Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ARNOLD - Ritchie Hwy. 02.1</u> d. STREET ADDRESS <u>RED 2 Box 188</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>MABEL</u> First Middle Last <u>H. DUDLEY</u>			4. DATE OF DEATH Month Day Year <u>2-6-1967</u>												
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-25-82</u> yrs.		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>@ home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>FRED C. HINDS</u>					14. MOTHER'S MAIDEN NAME <u>CARRIE SAUNDERS</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NR</u>			16. SOCIAL SECURITY NO. <u>                    </u>			17. INFORMANT <u>Mr. George Towne</u>			Address <u>Above</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>                    </u>										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>February, 1952</u> , to <u>Feb.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-5-1967</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>E. Schnitzer</u>				22b. DATE SIGNED <u>2-8-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>EUGENE SCHNITZER M.D.</u>				22d. ADDRESS <u>3904 S. HANOVER ST. Balt. Md. 21225</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>2/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>				23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>							
24. FUNERAL DIRECTOR <u>Robert S. Saunders, Severna Park, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

01044

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are faintly visible.]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01645

01642

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Greensboro</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN b <b>9 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>70-3</b>			
3. NAME OF DECEASED (Type or print) First <b>Lunetta</b> Middle <b>(none)</b> Last <b>ERWIN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1885</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simpson Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Wheeler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary E. Wayman</b> Address <b>New York</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular accident</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>arteriosclerotic Cerebro Vascular Disease</b> DUE TO (c) <b>Dilatative Crebrosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(physician)</b> attended the deceased from <b>1-25-67</b> , 19 <b>67</b> , to <b>Feb. 6, 1967</b> , that (I) <b>did</b> see the deceased alive on <b>Feb. 6, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A. T. Allen</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen, M.D.</b>				22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-11-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graveside</b>		23d. LOCATION (City or Town) (County) (State) <b>Greensboro N.C.</b>	
24. FUNERAL DIRECTOR <b>William R. ...</b>				25a. REC'D BY REGISTRAR <b>FEB 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01646

CERTIFICATE OF DEATH

01643

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XXXX- GLEN BURNIE</b>			c. LENGTH OF STAY in 1b <b>35 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XXXX- GLEN BURNIE</b> 02-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL HOSPITAL</b>				d. STREET ADDRESS <b>221 OAK LANE S.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>LeRoy</b> Last <b>ESTELLE</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>20</b> Year <b>1967</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>AUGUST 23, 1903</b>		
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DEPT. MANAGER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL STORE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Frank Estelle</b>				14. MOTHER'S MAIDEN NAME <b>Lottie Reed</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW-1</b> <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>156-09-3222</b>		17. INFORMANT <b>Mrs. Janet A. Estelle (wife) Same as #2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular Failure</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Renal Failure</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/16/67</b> , 19 <b>67</b> , to <b>2-20</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>2-20</b> , 19 <b>67</b> , and that death occurred at <b>7:20</b> M, from causes and on the date stated above.								
22a. SIGNATURE <b>Hilary T. O'Herlihy</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/20/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Hilary T. O'Herlihy, M.D.</b>				22d. ADDRESS <b>5 Central Avenue, S.W., Glen Burnie, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01647

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01644

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>DA. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>16-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - Anne. Arnold. Gen</u>				d. STREET ADDRESS <u>3-C Laurel Hill Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>E</u> Last <u>Evans</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-23</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Harry Evans</u>				
14. MOTHER'S MAIDEN NAME <u>Lucy</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>504 12 3737</u>			17. INFORMANT <u>Shirley A Evans Greenbelt Md</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Howard</u>			M.D.		22. DATE SIGNED <u>2-1-67</u>		
EXAMINER'S NAME (Type) <u>E. L. Howard</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>  </u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 6, 1967</u>		23c. NAME OF CEMETERY OR <del>CHURCH</del> <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>			25a. REC'D BY REGISTRAR <u>FEB 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01645

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN lb <b>16 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>Rt-1, Box-378C</b>			
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Eleanor</b> Last <b>FARRINGTON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1898</b>		9. AGE (In years lost birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STATE of Md.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pittsburgh, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-36-5674</b>		17. INFORMANT <b>J.G. FARRINGTON, Edgewater, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral, left middle cerebral artery</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pyelonephritis with uremia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as doctor) attended the deceased from <b>Feb. 1, 19 67</b> to <b>Feb. 16, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Feb. 16, 1967</b> , and that death occurred at <b>1:30 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler, M.D.</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-20-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md</b>	
24. FUNERAL DIRECTOR <b>TA Hardisty, ANNAPOLIS, Md</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G386 2/27/67 mh

01649

CERTIFICATE OF DEATH

01646

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Ann</b> Last <b>FORRESTER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1891</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>A.A. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Booze</b>				14. MOTHER'S MAIDEN NAME <b>Eliza ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No *****</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clarence Forrester, Beard Point Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chema</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Renal Disease</b> DUE TO (c) <b>Cardiac failure</b>						INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Jan. 27</b> , 19 <b>67</b> , to <b>Feb. 19</b> , 19 <b>67</b> , that (I) <del>(the hospital)</del> last saw the deceased alive on <b>Feb. 19</b> , 19 <b>67</b> , and that death occurred at <b>6:05 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A.T. Allen</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-20-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen, M.D.</b>				22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davidsonville</b>		23d. LOCATION (City or Town) (County) (State) <b>Davidsonville A.A. Co, Md</b>	
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Annapolis, Md</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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A. T. Allen, M.D.  
62 Cathedral St., Annapolis, Md.

Burlai 8-WE-67 Davidsonville  
Davidsonville A.A. Co, Md

D. F. Allen, III Annapolis, Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01650

CERTIFICATE OF DEATH

01647

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel general</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Cora</u> Last <u>Fowler</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-72</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Columbus Buckmaster</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Ann Buckmaster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-54-5072</u>		17. INFORMANT <u>Daughter Island Creek</u> Address <u>—</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>overhydration</u> DUE TO (c) <u>arteriosclerotic vascular disease with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>renal atrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric fracture, hip right severe</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Acc</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her home</u>					
20c. TIME OF INJURY Month, Day, Year Hour, a.m. <u>2-10</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Calvert MD</u>	
21. I certify that (1) (this hospital) attended the deceased from <u>2-11-1967</u> to <u>2-24-1967</u> , that (1) (we) last saw the deceased alive on <u>2-24-1967</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Bohlmann</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold R. Bohlmann</u>				22d. ADDRESS <u>96 Cathedral St AA MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery, Port Republic, Calvert, Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>Calvert, Md.</u>	
24. FUNERAL DIRECTOR <u>A.A. Harkness &amp; Son, Port Republic, Md.</u>				25a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01651

CERTIFICATE OF DEATH

01648

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>83 MARKET ST</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ZGeorge</b> Middle <b>FOX</b> Last <b>FOX</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1876</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>EDUCATOR RET. PUBLIC SCHOOLS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CO. Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. CO. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE FOX</b>		14. MOTHER'S MAIDEN NAME <b>ADALINE COE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>GEORGE D. FOX #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC CYSTITIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <b>physician</b> attended the deceased from <b>Feb. 18</b> , 19 <b>67</b> , to <b>Feb. 18</b> , 19 <b>67</b> , that (I) <b>see</b> saw the deceased alive on <b>Feb. 18</b> , 19 <b>67</b> , and that death occurred at <b>11:30 AM</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward S. Beck</b>		22b. DATE SIGNED <b>2/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>		22d. ADDRESS <b>73 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>2/20/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FORK METHODIST CH</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE CO MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR. SONS ANNAPOLIS MD.</b>		25. REC'D BY REGISTRAR <b>FEB 21 1967</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Ann Arbor General Hospital  
Ann Arbor, Mich

Male	White	George
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U.S.	ANNAPOLIS	U.S.
George Fox	ADALINE Coe	George D Fox

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ANNAPOLIS

GENERIC CHART

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11:30 AM  
73 Franklin St., Annapolis, Md.

Feb. 18 07  
11:30 AM  
73 Franklin St., Annapolis, Md.

Barber 2/20/1897 Fork Methodist Ch  
John M. Taylor 2nd Annapolis Md

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b telephone call - Singleton F. H. 2/8/67 cac

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01652

01649

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ADCO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ADCO</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Haven</u>			c. LENGTH OF STAY IN 1b <u>211111</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paradise</u> <u>021</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North Annapolis Hosp.</u>				d. STREET ADDRESS <u>Box 40A - Rt #1 Bayside Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ISADOL</u> Middle <u>S.</u> Last <u>Fry</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-2-19</u>		
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NSA (Gov't)</u>		11. BIRTHPLACE (State or foreign country) <u>Shippensburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Davis A. Shank</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Group</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>174-05-2800</u>		17. INFORMANT <u>Kenneth L. Fry (Husband)</u> Same as # <u>2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous Generalized</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>E. L. Libbert</u> M.D.				22. DATE SIGNED <u>2-1-67</u>				
EXAMINER'S NAME (Type) <u>E. L. Libbert</u>				Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Fort Meyer, Va.</u>		
24. FUNERAL DIRECTOR <u>Eugene B. Flannery</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01650

01653

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL—CAPE ST. CLAIRE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE ST. CLAIRE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 96 R.F.D.#4—CAPE ST. CLAIRE</u>		d. STREET ADDRESS <u>Box 96 R.F.D.#4</u>	
3. NAME OF DECEASED (Type or print) <u>Clara</u> First <u>L</u> Middle <u>GASIOR</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-98</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL BARYLSKI</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-46-4063</u>	
17. INFORMANT <u>ALBERT F. GASIOR</u> Address <u>Box 96 R.F.D.#4 CAPE ST. CLAIRE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident with terminal</u> 260X DUE TO <u>Bilateral Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Diabetes late apparition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>63</u> , to <u>February 20</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>February 20</u> , 19 <u>67</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand C. R. Gau</u>		ADDRESS (Street, city or town, state) <u>Box 177 Rt. 4 Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand C. R. GAU</u>		DATE SIGNED <u>2-21-67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/23/67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u> ADDRESS <u>705 SOUTH ANN ST</u>		24a. REC'D BY REGISTRAR <u>Feb 21 1967</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01654

01651

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>193 Woods Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Holden</b> Last <b>GEORGE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1922</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AACo</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HARRY Lee Holden</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE COURSEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-14-3599</b>	
17. INFORMANT <b>A.E. George</b>		Address <b>193 Woods Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatic heart disease, mitral insufficiency.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b> <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (do hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>Feb.</b> , 19 <b>67</b> , that (I) (do not) saw the deceased alive on <b>Feb. 26</b> , 19 <b>66</b> , and that death occurred at <b>9:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John L. Hedeman</b>		22b. DATE SIGNED <b>2/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>		22d. ADDRESS <b>1407 Forest Drive, Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville</b>	23d. LOCATION (City or Town) (County) (State) <b>Sudlersville, Md AACo</b>
24. FUNERAL DIRECTOR <b>TA HARDESTY</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>ANNAPOLIS, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01655

01652

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>3525 South River Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>Babette</b> Middle <b>GERHAB</b> Last <b>GERHAB</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 19, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>BRUNO MILLER</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET HEINEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>LOCH HAVEN BEECH</b> <b>MRS. SAMUEL CRAWFORD A.A.C. MD</b>		18. ADDRESS	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal shutdown</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular accident</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> , 19 <b>66</b> , to <b>2/3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>February 3</b> , 19 <b>67</b> , and that death occurred at <b>10:35 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b>		22b. DATE SIGNED <b>2/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, MD</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-8-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLSIDE CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>PHILA. PA.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR'SONS ANNAPOLIS MD</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARGARET HEINEL  
LOCH HAVEN BEACH  
MRS SAMUEL CRAWFORD A.C. RD

BRUNO MILLER  
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BRUNO 2-8-1947 Hillside Cem. PHILA  
JENNIE M. TAYLOR'S ADDRESS NO.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01656

CERTIFICATE OF DEATH

01653

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6043 Ritchie Hwy.</b>				d. STREET ADDRESS <b>6043 Ritchie Hwy.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>D.</b> Last <b>GREEN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1888</b>	9. AGE (In years lost birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joshua Green</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen DeBow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W W I</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Rita Green (same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma Liver lungs</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Stomach</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 19 <b>57</b> , to <b>Feb 2</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb 1</b> , 19 <b>67</b> , and that death occurred at <b>12:30</b> AM, from causes and on the date stated above.							
22a. SIGNATURE <b>Sam Berd</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin Berdann</b>				22d. ADDRESS <b>5010A Gov. Ritchie Hwy., Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-4-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hwy. k A.A.Co., Md.</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1910

ESTIMATE OF DATA

1910

COUNTRY			
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01657

01654

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>103 HUSE DR</b>	
3. NAME OF DECEASED (Type or print) First <b>Grover</b> Middle <b>STEVENSON</b> Last <b>GRIMES, Sr.</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-20-1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>H.A. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN GRIMES</b>		14. MOTHER'S MAIDEN NAME <b>HARDY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ELIZABETH D. GRIMES #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary artery disease</b> DUE TO (c) <b>Arteriosclerosis cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>was</del> attended the deceased from <b>Jan</b> , 19 <b>55</b> , to <b>Feb 21</b> , 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>Feb 10</b> , 19 <b>67</b> , and that death occurred at <b>7:10 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Samuel Borssuck</b>		22b. DATE SIGNED <b>2/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Borssuck, M.D.</b>		22d. ADDRESS <b>Amos Garrett Blvd., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>BURIAL</b>	<b>2-24-67</b>	<b>HENDERSON METH. Cmt.</b>	<b>CALLAO</b>
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS	
<b>Annapolis, Md.</b>		<b>DATE FEB 28 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Annopolis, Md.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01658

01655

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;"><b>MARYLAND</b></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. LENGTH OF STAY IN lb <u>Life Time</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route #2, Box 18</u>				d. STREET ADDRESS <u>Route #2, Box 18</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Essie Viola Hamilton</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>20</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 15, 1896</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Severn, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Samuel Harris</u>				
14. MOTHER'S MAIDEN NAME <u>Mariah Gamble</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>215-16-2382</u>			17. INFORMANT <u>Mr. Clarence Hamilton</u>				
18. ADDRESS <u>Route 2 Box 18</u>			18. ADDRESS <u>Hanover, Md</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Rt. Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 yr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>	20f. (City or town) <u>Hanover</u>	(County) <u>Anne Arundel</u>	(State) <u>Md</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1, 1967</u> to <u>Feb. 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 1, 1967</u> , and that death occurred <u>3:55</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank E. Shipley, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 22, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>		22d. ADDRESS <u>Savage, Md - 2/22/67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National Cem</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter</u>					
ADDRESS <u>3035 W. North Ave</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

018558

018558

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FOR STATE  
HEALTH DEPT.

01659

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01656

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>02-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dr. A. General</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>123 Bunche St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Abraham Hebron</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-26-1900</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>2-2-1967</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Hebron</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>4500</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u> 17. INFORMANT <u>Elizabeth Hebron</u> Address <u>123 Bunche St.</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>2/2/67</u> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-5-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR <u>William Reese</u> ADDRESS <u>Anna. Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 6 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01653

*Admission number*

*Chen*

*4/1/7*

1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01660

CERTIFICATE OF DEATH

01657

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>443 Grain Highway N/E</u>	
3. NAME OF DECEASED (Type or print) <u>Charles L. Hein Sr.</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 31, 1899</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>02</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fuel Oil</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fairfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hein</u>		14. MOTHER'S MAIDEN NAME <u>Anna Grothey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216/05/8657</u>	
17. INFORMANT <u>Mrs Helen R. Hein</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coring thrombosis</u> DUE TO (b) <u>Advanced Coring Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>63</u> , to <u>2/2</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2/2</u> , 19 <u>67</u> , and that death occurred at <u>4:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Wayne B. Jato</u>		22b. DATE SIGNED <u>2/3/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn RFD Md.</u>	
24. FUNERAL DIRECTOR <u>R.V. SINGLETON</u>		25a. REC'D BY REGISTRAR <u>GLEN BURNIE, MD.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 10 1967</u>	

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STATE OF NEW YORK

IN SENATE  
JANUARY 1, 1910

REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1910

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS  
1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

01661

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01658

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ft. Geo. Meade,</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kimbrough Army Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>JESSUP</b> d. STREET ADDRESS <b>Box 419 - A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>LESTER DEWEY HIGGS</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>February 1, 1967</b> Month Day Year											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>23 April 1899</b>		<b>9. AGE</b> (In years last birthday) <b>67</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter (Ret)</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Stanley, Virginia</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Thomas J. Higgs</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Barbara E. Painter</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes Oct 1919-Oct 1922</b>				<b>16. SOCIAL SECURITY NO.</b> <b>212-09-1508</b>		<b>17. INFORMANT</b> <b>Mrs. Lottie L Higgs, Same as #2</b> Address									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/9/67</b> , <b>1967</b> , to <b>2/1/67</b> , <b>1967</b> , that (I) (we) last saw the deceased alive on <b>1/23/67</b> , <b>19</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <b>Joseph E. Smith, Jr.</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Joseph E. Smith, Jr. M.D.</b>						<b>22d. ADDRESS</b> <b>Burtonsville, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>23b. DATE THEREOF</b> <b>Feb. 4, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Good Shepherd Cemetery, RFD, Ellicott City, Maryland</b>				<b>23d. LOCATION</b> (City, town or county) (State)					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Harold S. Wade</b>						<b>ADDRESS</b> <b>550 Wash. Blvd. Laurel, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 8 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G386 2/24/67 mh

01662

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01659

1. PLACE OF DEATH a. COUNTY <u>ARCO</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ARCO</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>02-1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bucks 26, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Don - Harsh Arnold Hosp</u>			d. STREET ADDRESS <u>1005 Park Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry W. Hobson</u>			4. DATE OF DEATH Month Day Year <u>2 15 1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/1914</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
13. FATHER'S NAME <u>William Hobson</u>			14. MOTHER'S MAIDEN NAME <u>Maudie Cottermuth</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-3167</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1344</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D.		22. DATE SIGNED <u>2/15/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>211/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	23d. LOCATION (City or Town) <u>Glen Burnie</u>	(County) <u>AA</u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>McColly</u>			25. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

016228

016228



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01663

01660

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>2-2nd Ave</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2-2nd Ave Balto 21225</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>A A Co</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2-2nd Ave</b> d. STREET ADDRESS <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Agnes M Hooper</b>		<b>4. DATE OF DEATH</b> Month <b>Feb</b> Day <b>17</b> Year <b>19 67</b>					
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Cau</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct 13, 1906</b>	<b>9. AGE</b> (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Md</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>George T Hooper</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Louise Schneider</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Family</b> Address <b>Same</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of (R) Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>	(County) (State)		
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>1 Feb 63</b> , 19 <b>63</b> , to <b>17 Feb</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>17 Feb 67</b> , 19 <b>67</b> , and that death occurred at <b>4:00</b> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>[Signature]</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/20/67</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A. R. Sosnowski</b>		<b>22d. ADDRESS</b> <b>4016 Ritchie Hwy Balto Md</b>					
<b>23a. BURIAL, CREMATION, REMAINS</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/21/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cem</b>			
<b>23d. LOCATION</b> (City, town or county) <b>A A Co.</b>		(State) <b>Md</b>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>McCully F H</b>			ADDRESS <b>237 Patapsco Ave 21225</b>				
<b>25a. REC'D BY REGISTRAR</b>			<b>25b. REGISTRAR'S SIGNATURE</b> <b>[Signature]</b>				
DATE <b>FEB 21 1967</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01664					01664									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FT GEO. G. MEADE					c. LENGTH OF STAY IN lb 2 HOURS									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ODENTON									
4. DATE OF DEATH Month Day Year FEBRUARY 7 1967					d. STREET ADDRESS 570 RITA DRIVE									
3. NAME OF DECEASED (Type or print) First Middle Last WASHINGTON I HOUGHTON					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 15, 1915		9. AGE (In years last birthday) yrs. 51						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY, MD.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME ERNEST HOUGHTON					14. MOTHER'S MAIDEN NAME Beulah Jones									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES Jun 43-Oct 63					16. SOCIAL SECURITY NO. 579-01-2185					17. INFORMANT DOROTHY L. HOUGHTON (W) 570 Rita Drive ODENTON, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's Cirrhosis										2 HOURS				
5811 DUE TO (b) Peritonitis														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) <del>physician</del> attended the deceased from Feb 7, 1967, to Feb 7, 1967, that (I) <del>was</del> last saw the deceased alive on Feb 7, 1967, and that death occurred at 1140 AM, from the causes and on the date stated above.														
22a. SIGNATURE George J. Ramirez										22b. DATE 7 February 1967				
22c. PHYSICIAN'S NAME JORGE J. RAMIREZ, CPT, MC										22d. ADDRESS KIMBROUGH AN FORT GEORGE G. MEADE, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 10, 1967			23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City, town or county) (State) Ft. Myer, Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home										25a. REC'D BY REGISTRAR DATE FEB 10 1967		25b. REGISTRAR'S SIGNATURE J. L. Judge		

13310

13310

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

HOSPITAL

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

NAME OF DECEASED

CAUSE OF DEATH

11

DATE OF DEATH

PLACE OF DEATH

7 1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01665					01662				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>none Box 159, Ft. Smallwood Rd.</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>FT. Smallwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Richard Elmer Houser</u>			4. DATE OF DEATH <u>February 20 1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1911</u>		9. AGE (in years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Scrap Co.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Fredricks, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Houser</u>					14. MOTHER'S MAIDEN NAME <u>-----</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW 2</u>		17. INFORMANT <u>Elizabeth Houser</u>		Address <u>Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>essential hypertension</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>2 years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1950</u> to <u>Feb. 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 13, 1967</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>R. M. McLaughlin</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/20/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>					22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-22-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hgwy., Baltimore</u>					25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Gonce</u>		



01003  
4/1/10

CO. 1010 OF 1010

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*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

*[Faint, mostly illegible handwritten text, possibly a signature or address.]*

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01666

01663

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>703 Severn Ave.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Anthony</b> Last <b>HUGHES</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1914</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Publications Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>EASTPORT Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOSEPH HUGHES</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE Winchester</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>WWII 214-05-2580</b>		17. INFORMANT <b>Mrs J.F. Gomoljak</b> Address <b>ANNAPOLIS, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>2-4 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>2/11, 1967</b> , to <b>Feb. 11, 1967</b> that (I) (we) last saw the deceased alive on <b>Feb. 11, 1967</b> , and that death occurred at <b>6:45 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman M.D.</b>				22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>		23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS, MD ADCo.</b>	
24. FUNERAL DIRECTOR <b>TA Hardisty</b>				ADDRESS <b>12 Ridgely Ave, ANNAPOLIS, MD</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 21 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01667

01664

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie,</b> d. STREET ADDRESS <b>1109 Armistead St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carrie B. Hull</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-84</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY	
10. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
12. FATHER'S NAME <b>SAMUEL KEEFER</b>		13. MOTHER'S MAIDEN NAME <b>MARGARET ZIES</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		15. SOCIAL SECURITY NO.	
16. INFORMANT		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>4200</b> DUE TO (b) <b>Obstructed coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b> <b>yes</b>	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		19b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that (I) (this hospital) attended the deceased from <b>2-15-1967</b> , to <b>2-16-1967</b> , that (I) (we) last saw the deceased alive on <b>2-16-1967</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
21a. SIGNATURE <b>Harold J. Moore</b>		21b. DATE SIGNED <b>2-16-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2.18.67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REHOBETH METHODIST</b>		23d. LOCATION (City, town or county) (State) <b>FULTON COUNTY PENNA.</b>	
24. FUNERAL DIRECTOR <b>Howard J. Moore</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Moore</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01668

CERTIFICATE OF DEATH

01665

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before birth) <u>Maryland</u> a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>3 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Anne Arundel Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>PATRICK</u> Last <u>HUMMER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>SM</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-66</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Wesley Hummer</u>		14. MOTHER'S MAIDEN NAME <u>Donna Marie Bligh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Paul W. Hummer</u>		Address <u>(Same as #2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory Failure</u> 7730 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Etiology undetermined</u> DUE TO (c) <u>8 hours</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5</u> , 1967, to <u>Feb 5</u> , 1967, that (I) (we) last saw the deceased alive on <u>Feb 5</u> , 1967, and that death occurred at <u>6:10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Kopack MD.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/5/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. KOPACK</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Date of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Montgomery Co. Md.</u>
24. FUNERAL DIRECTOR <u>L. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23910

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01663					CERTIFICATE OF DEATH					01666				
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenland Beach</b>			c. LENGTH OF STAY IN 1b <b>35 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenland Beach</b>					02-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8052 Ft. Smallwood Road</b>					d. STREET ADDRESS <b>8052 Ft. Smallwood Rd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>MATTHEW</b> Last <b>JEFFERSON</b>					4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>1967</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 17, 1905</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNOER 1 YEAR Months <b></b> Days <b></b>		IF UNOER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Parts dealer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				
13. FATHER'S NAME <b>Albert Jefferson</b>					14. MOTHER'S MAIDEN NAME <b>Eva Shultz</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-32-5457</b>		17. INFORMANT <b>Mrs. Thelma Jefferson</b>				Address <b>Same</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary arteriosclerotic heart disease</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>diabetes mellitus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic osteomyelitis 30 years</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>18 years</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>June 1, 1930</b> , to <b>February 2, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Feb. 2, 1967</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>R.M. McLaughlin</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/2/67</b>							
22c. PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b>					22d. ADDRESS <b>3708 Mountain Rd. Pasadena, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>						
24. FUNERAL DIRECTOR <b>George J. Gonce</b>					ADDRESS <b>4001 Ritchie Hwy. (21225)</b>		25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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February 1999

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10.1017/S000712260000199

bioRxiv preprint doi: <https://doi.org/10.1101/2017.07.27.182520>; this version posted July 28, 2017. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

739 N. E. 1st St.

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Figure 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01670

CERTIFICATE OF DEATH

01667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>			c. LENGTH OF STAY IN IB <u>1 Day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Pasadena 21122</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>201 Mission St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Benton</u> Middle <u>(nmi)</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/15/92</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Linthicum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-34-6855</u>		17. INFORMANT <u>Mrs. Gladys D. Johnson (wife)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1956</u> , to <u>Feb. 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 24 1967</u> , and that death occurred at <u>4:30 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Francis I. Codd</u>				ATTENDING PHYS. <u>XXXX</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd, MD</u>				22d. ADDRESS <u>Ritchie Highway, Severna Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>				ADDRESS <u>Glen Burnie, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01370

01370

STATE OF NEW YORK  
IN SENATE  
January 1, 1965  
REPORT  
OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
SOCIAL SERVICES  
ON THE  
ADMINISTRATIVE  
AND FINANCIAL  
OPERATIONS OF THE  
DEPARTMENT OF  
SOCIAL SERVICES  
FOR THE YEAR  
1964  
ALBANY: THE UNIVERSITY OF THE STATE OF NEW YORK PRESS, 1965  
PUBLISHED BY THE UNIVERSITY OF THE STATE OF NEW YORK PRESS  
ALBANY, NEW YORK 12244  
1965

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**01671**

**CERTIFICATE OF DEATH**

**01668**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN b <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>39 Calvert St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Carla Ann JOHNSON</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>February 12 19 67</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct. 13, 1966</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>3 30</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Anne Arundel, Maryland</b>			
<b>13. FATHER'S NAME</b> <b>Vernon Johnson</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Barbara Wallace</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Barbara Wallace 39 Calvert St.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 hours</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (the hospital) attended the deceased from Feb. 12, 1967, to Feb. 12, 1967 that (I) (the hospital) saw the deceased alive on Feb. 12, 1967, and that death occurred at M, from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Charles B. Hargrove</b> M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/13/67</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Charles B. Hargrove, M.D.</b>			<b>22d. ADDRESS</b> <b>Hahn Prof Bldg., Severna Park, Md.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>23b. DATE THEREOF</b> <b>2-16-1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Brewer Hill Annapolis Md.</b>			
<b>23d. LOCATION (City or Town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>William Reese Jr. Annapolis</b>			<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		
<b>DATE</b> <b>FEB 14 1967</b>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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January 1954

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*Abstract*

Figure 1. Schematic diagram of the experimental setup.

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Oct. 18, 1966

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01672

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01669

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie-rural</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel General</b>				d. STREET ADDRESS <b>2200 1/2 Eutaw Place</b>			
3. NAME OF DECEASED (Type or print) First <b>Rosetta</b> Middle <b>K.</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 20, 1939</b>	9. AGE (In years last birthday) <b>27</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VNK.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>VNK.</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Eaddy</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Jack H. Johnson</b>		Address <b>3832 Reisterstown</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3220</b> <b>Acute alcoholic intoxication, possibly associated with exposure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>DUE TO</b> (c) <b>DUE TO</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>			M.D. <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Arbutus Md.</b>			
24. FUNERAL DIRECTOR <b>Mortono Dyett F.H.</b>				25a. REC'D BY REGISTRAR <b>1701 Laurens St.</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	
				DATE <b>FEB 23 1967</b>			

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GERMAN LABORERS - 1944-1945

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1#</p> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>01673</b></p> </div> <div> <p><b>01670</b></p> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor 7355 Turner Blvd</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30-4</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>William E. Johnson</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>23</u> Year <u>1967</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-25-1894</u> <b>9. AGE</b> (In years last birthday) <u>72</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Janitor</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hospital</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Belair, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Ross Johnson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Stump</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>W-W-1</u> <b>17. INFORMANT</b> <u>Ken Wallace</u> Address <u>1120 Abbott Ct.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO <u>hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>decompensation</u> (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u> Duration <u>Unknown</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 20</u> , 19 <u>66</u> , <b>to</b> <u>Feb 23</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 18</u> , 19 <u>67</u> , <b>and that death occurred at</b> _____ M, <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Richard H. Hunt</u>						<b>22b. DATE SIGNED</b> M.D. _____		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Richard H. Hunt</u>		<b>22d. ADDRESS</b> <u>100 Cherry Lane, Glen Burnie, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2-27-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>National Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Md.</u> (State) _____			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Randolph J. Collick</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>DATE</b> <u>FEB 28 1967</u>	

01510

01510

FEB 28 1961

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01674

01671

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>131 West St.,</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Davis</b> Last <b>JONES</b>			4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1913</b>		9. AGE (In years last birthday) <b>53</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Maryland</b>	
13. FATHER'S NAME <b>William Davis</b>			14. MOTHER'S MAIDEN NAME <b>Babara Taylor</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-4923</b>		17. INFORMANT <b>Clinton Dorsey, 112 South Villa Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>87%</b>					INTERVAL BETWEEN ONSET AND DEATH <b>87%</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>7-12-66</b> 19 <b>66</b> , to <b>2-15-</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-3-</b> 19 <b>67</b> , and that death occurred at <b>10:20 AM</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Frank M. Shipley</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK M. SHIPLEY</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Best gate Rd A.A. Md</b>	
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Annapolis, Md</b>		25a. REC'D BY REGISTRAR <b>FEB 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

17910

35610



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
016725						01672					
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>				c. LENGTH OF STAY IN lb <i>35 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <i>Hugh Evans Jones, Jr.</i>						4. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>1967</i>					
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 18, 1890</i>		9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i>76</i> Days <i>19</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boat Builder</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Civil Service</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Dalzell, South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ROBERT LEE JONES</i>						14. MOTHER'S MAIDEN NAME <i>FRANCES ?</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>220-03-8451</i>		17. INFORMANT <i>Hugh E. Jones, Jr.</i>		Address <i>23 Harvart Rd, Bay Ridge, Annapolis, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac failure</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arteriosclerotic Cardio-Vascular disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary Emphysema</i>										INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i> <i>2 years.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>JAN. 4</i> , 1967 to <i>Feb. 19</i> , 1967, that (I) (we) last saw the deceased alive on <i>Feb. 19</i> , 1967, and that death occurred at <i>7:50 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Sylvia M. Lin</i>						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/20/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sylvia M. Lin</i>						22d. ADDRESS <i>Rt 1 Box 244 Edgewater, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>2-22-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest</i>		23d. LOCATION (City, town or county) (State) <i>Annapolis Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>						ADDRESS <i>Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

01613

01613

Page 2

Project 400-1000

Project 400-1000

Page 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01676

01673

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>LAYMON</b> Last <b>LAYMON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1906</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>02</b> Days <b>1</b> Hours <b>00</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11c. BIRTHPLACE (County & State or foreign country) <b>West Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Morris Balto Md</b>		Address <b>Balto Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration</b> DUE TO (c) <b>Cerebrovascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>13 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Jan. 23, 1967</b> , to <b>Feb. 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5, 1967</b> , and that death occurred at <b>5:15 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>R. Biern</b>		22b. DATE SIGNED <b>2/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert O. Biern, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-8-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chew's Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Chesapeake Md</b>	
24. FUNERAL DIRECTOR <b>William Reesett Anna Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 8 1967</b>	

01013

01013

1. Name of the person

2. Address

3. Date of birth

4. Place of birth

5. Date of death

6. Cause of death

7. Date of burial

8. Place of burial

9. Name of the person

10. Address

11. Date of birth

12. Date of death

13. Date of burial

14. Place of burial

15. Date of birth

16. Date of death

17. Cause of death

18. Name of the person

19. Address

20. Date of birth

21. Name of the person

22. Address

23. Date of birth

24. Date of death

25. Cause of death

26. Date of burial

27. Place of burial

28. Name of the person

29. Address

30. Date of birth

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01677

CERTIFICATE OF DEATH

01674

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>7 mos. 4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1040 E. Lombard Street</u>	
3. NAME OF DECEASED (Type or print) # <u>32736</u> <u>John</u> <u>N.</u> <u>Leebrick</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1897</u>
9. AGE (In years last birthday) <u>68</u> <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Leebrick</u>		14. MOTHER'S MAIDEN NAME <u>Ida Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-4525</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome sec. to Alcoholism, Inanition</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-----</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that (I) (this hospital) attended the deceased from <u>7/21/66</u> , 19 <u>66</u> , to <u>2/17/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>2/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-----</u>	23d. LOCATION (City or Town) (County) (State) <u>Richburg, Va.</u>
24. FUNERAL DIRECTOR <u>Leebrick Funeral Home Balt Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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2000

01852



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01678					01675					
Item #23b, c & d File #J385-2/20/67 pc										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> c. LENGTH OF STAY IN 1b <b>Brooklyn</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>314 W. 14th. Ave.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> d. STREET ADDRESS <b>314 W. 14th. Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mamie Leiman</b>					4. DATE OF DEATH <b>Feb. 12, 1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 2, 1888</b>		9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR: Months Days Hours Mln.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ho usewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Balto Md</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frederick Jacob</b>					14. MOTHER'S MAIDEN NAME <b>Louisa Bartel</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mrs. Ruth Norris</b>			Address <b>314 W. 14th. Ave</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction with extension</b> DUE TO (b) <b>extension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Coronary artery disease with Left Bundle Br. Block</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <b>30 days.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12/29</b> , 19 <b>66</b> , to <b>2/12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/12</b> 19 <b>67</b> , and that death occurred at <b>6:00</b> M, from the causes and on the date stated above.										
22a. SIGNATURE <b>Wm. W. Guerin</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 13, 1967</b>			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			23d. LOCATION (City, town or county) (State) <b>A.A. Co. Md.</b>		
24. FUNERAL DIRECTOR <b>McCully Funeral Home</b>					ADDRESS <b>237 Patapsco Ave.</b>					
25a. REC'D BY REGISTRAR <b>FEB 15 1967</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01676

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>City Baltimore 29</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>653 Brisbane Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Clara</b> Last <b>LOESCHKE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 13, 1891</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
13. FATHER'S NAME <b>John Debes</b>				14. MOTHER'S MAIDEN NAME <b>Mary W. Hoenig</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-46-1783</b>		17. INFORMANT <b>Mr. Paul H. Loeschke, Jr.</b> Address <b>653 Brisbane Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure, acute</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction, anteroseptal</b> DUE TO (c) <b>Arteriosclerosis, general and coronary</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b> <b>24 days</b> <b>several years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>January 12, 1967</b> , to <b>February 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>February 4, 1967</b> , and that death occurred at <b>6:20 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Charles W. Kinzer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>February 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>				22d. ADDRESS <b>South River Medical Building Edgewater, Maryland 21037</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-7-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>3801 Frederick Ave. Balto, Md.</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01680

01677

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FT GEO G. MEADE, MD</b> c. LENGTH OF STAY IN b <b>50 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT GEORGE G. MEADE, MARYLAND</b> d. STREET ADDRESS <b>7536 WILLS STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ESTHER</b>		First <b>L.</b>		Middle <b>LUCAS</b>		Last <b>Lucas</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 MARCH 1913</b>		9. AGE (In years last birthday) yrs. <b>53</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FORT CLINTON, OHIO(OHAWA)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HARRY H. KERR</b>				14. MOTHER'S MAIDEN NAME <b>JESSIE PATTERSON</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>CHARLES L. LUCAS(H)</b>		7536 WILLS STREET <b>FT GEO G. MEADE, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia with pneumonia</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Invasive Squamous Cell Carcinoma of Cervix</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 Jan</b> , 19 <b>67</b> , to <b>25 Feb</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>25 Feb 67</b> , 19 <b>67</b> , and that death occurred at <b>10:00 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Joseph S. Betts</b>				M.D. <b>JOSEPH S. BETTS, CPT, MC</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>25 Feb 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BETTS, CPT, MC</b>				22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL, FT GEO G. MEADE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>March 1, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATINAL CEMETERY, Rt. Myer, Virginia</b>		23d. LOCATION (City, town or county) (State) <b>MD</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harold S. Wade, Laurel, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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01677

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
TO: [Illegible]  
FROM: [Illegible]  
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

March 1, 1952

MAR 2 1952



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01681					01678					
1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atz</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Manor</u>					d. STREET ADDRESS <u>Harford</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JACKSON</u> First <u>LYONS</u> Middle Last					4. DATE OF DEATH <u>2-3-67</u> Month Day Year <u>19</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hem.</u> <u>4221</u> DUE TO <u>acc vld</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Senail</u> (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>21 Jan 67</u> , 19 <u>67</u> to <u>2-3-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 1 67</u> , 19 <u>67</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Robert O. Peterson</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>R. HAHN</u>					22d. ADDRESS <u>P.O. Box 73 Saveno Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Mount Cent</u>		23d. LOCATION (City, town or county) (State) <u>Rocky Mount N.C.</u>			
24. FUNERAL DIRECTOR <u>C. C. Stokes</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					DATE <u>FEB 20 1967</u>					

01681

01681



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01682

01679

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Severn Park</u> d. STREET ADDRESS <u>276 Pertsch Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Allen</u> Last <u>Macey</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>19</u> Year <u>1967</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 19, 1967</u>		<b>9. AGE</b> (In years last birthday) <u>8</u> <u>40</u> <u>40</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>40</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Anne Arundel Co. Glen</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>James Albert Macey</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Carol Irene Dail</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Mother</u> <u>276 Pertsch Rd. Severn Park Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS SYNDROME</u> <u>7735</u> DUE TO (b) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8:40</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>19 Feb</u>, 19<u>67</u>, to <u>19 Feb</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>19 Feb</u> 19<u>67</u>, and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Sherman Robinson</u>								<b>22b. DATE SIGNED</b> <u>19 Feb 67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Sherman Robinson</u> M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.					
<b>22d. ADDRESS</b>								<b>22e. ADDRESS</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>				<b>23b. DATE THEREOF</b> <u>2-24-67</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>North Arundel Hospital</u>				<b>23d. LOCATION</b> (Only town or county) (State) <u>Glen Burnie, Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Alfred J. ...</u>				<b>24a. ADDRESS</b> <u>Administrator</u>				<b>25a. REC'D BY REGISTRAR</b> <u>2-24-67</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

ES310

32316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01683

01680

1. PLACE OF DEATH a. COUNTY <u>G.A. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>G.A. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GENBURNIE</u>		c. LENGTH OF STAY IN IB <u>D.C.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>136 W. B. &amp; A. Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>LEE</u> Last <u>HELLAS</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 25, 1905</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Molder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hellas</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Whitlock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-03-9330</u>	
17. INFORMANT <u>Dr. Louis Hellas</u>		Address <u>136 W. B. &amp; A. Rd. Seneca, Ind.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary attack</u> 5271 DUE TO <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Notal Insufficiency 3 years</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>4 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/25/65</u> , 19 <u>  </u> , to <u>Feb 8/67</u> , that (I) (we) last saw the deceased alive on <u>Feb 6/67</u> , 19 <u>  </u> , and that death occurred <u>1939A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Louis Hellas</u> M.D.		22b. DATE SIGNED <u>2/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Louis Hellas</u>		22d. ADDRESS <u>Indianapolis Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Greets Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Connor, Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>901 Hollis St 21223</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 9</u>		1967	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

01685

**CERTIFICATE OF DEATH**

01682

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>49 W. Washington St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Sarah</b> Middle <b>Blaney</b> Last <b>MILLER</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>1</b> Year <b>1967</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>November 17, 1894</b>		<b>9. AGE</b> (In years lost birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>					
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>218-14-225</b>		<b>17. INFORMANT</b> <b>James A. Wells</b> Address <b>Anna, Md.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>H+H.C.V.D</b> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 28</b> , 19 <b>67</b> , to <b>Feb 1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb 1</b> , 19 <b>67</b> , and that death occurred at <b>2:25 A.M.</b> from causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Faye W. Allen</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/1/67</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Faye W. Allen</b>				<b>22d. ADDRESS</b> <b>62 Cathedral St Annapolis Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2-4-1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St Annis</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Annapolis Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>William Reese # Anna Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 2 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01686

CERTIFICATE OF DEATH

01683

1. PLACE OF DEATH a. COUNTY <u>AA.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> c. LENGTH OF STAY in 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u> d. STREET ADDRESS <u>Rt 10 -</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PROLINE E. MYERS.</u> First Middle Last 4. DATE OF DEATH <u>2/16/67</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/17/93</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State of foreign country) <u>Ind.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Family - Son</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>193X</u> <u>1. Pagets Discharge of bone</u> <u>2. Atherosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3/30/65</u> , 19 <u>65</u> , to <u>1/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive at <u>1/31</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Ray M. Smith</u> 22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith, M.D.</u> 22b. DATE SIGNED 22d. ADDRESS <u>Hahn Professional Building, Sev. Pk., Md</u>		23a. BURIAL CREMATION, REMOVAL (Specify) <u>2/20/67</u> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <u>St Michaels</u> 23d. LOCATION (City or Town) (County) (State) <u>Beth</u>	
24. FUNERAL DIRECTOR <u>Mr. Casey - 237</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 21 1967</u> 25b. REGISTRAR'S SIGNATURE			

01880

STATE OF TEXAS

01880



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01687

01684

Item 7 Film 9386 2/24/67 mh

1. PLACE OF DEATH a. COUNTY Anne Arundel				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 19 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				02-1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Fourth Ave. S/E								d. STREET ADDRESS 111 Fourth Ave. S/E				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELENA				Middle BERTHA				Last NAUMANN				4. DATE OF DEATH Month 2			
Day 16				Year 1967											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/84		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months —		IF UNDER 24 HRS. Days —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (Kriewald)				14. MOTHER'S MAIDEN NAME Louisa Lehn											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-54-1892				17. INFORMANT il (Louise Kressler - Same as # 2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO MYOCARDIAL INFARCTION (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis												INTERVAL BETWEEN ONSET AND DEATH 9 min 10 yrs 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —											
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/10, 1967 to 2/8, 1967, that (I) (we) last saw the deceased alive on 2/8, 1967, and that death occurred at 11 P. M. from the causes and on the date stated above.															
22a. SIGNATURE J. W. Prichard				M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 2/17/67			
22c. PHYSICIAN'S NAME (Type) R. W. PRICHARD MD				22d. ADDRESS Glen Burnie, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/20/67				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town, or county) (State) Brooklyn Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE R. W. Prichard				ADDRESS Singleton Funeral Home/ Glen Burnie, Md,				25a. REC'D BY REGISTRAR DATE FEB 20 1967				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

01684

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01688

CERTIFICATE OF DEATH

01685

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN lb <b>Severn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Norht Arundel Hospital</b>		d. STREET ADDRESS <b>Rt #2 Box 89 Reese Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Vernon</b> Middle <b>Roland</b> Last <b>Norris</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1909</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>9</b> Hours <b>24</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Const.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Gaithersburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(unknown) Balton</b>		14. MOTHER'S MAIDEN NAME <b>Della (unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>244-483-1111</b>	
17. INFORMANT <b>Mrs. Deanna M. Nehring</b>		<b>Glen Burnie, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary attack</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 3, 1967</b> to <b>Feb 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 3, 1967</b> , and that death occurred at <b>Severn, Md.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Lirskey</b>		22b. DATE SIGNED <b>2/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH LIRSKEY</b>		22d. ADDRESS <b>TELEGRAPH ROAD, SEVERN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem'l Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>
24. FUNERAL DIRECTOR <b>R.V. SINGLETON</b>		25a. REC'D BY REGISTRAR <b>GLEN BURNIE, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 10 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED 10 MAR 1967

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1. NAME (Last, First, Middle)		2. GRADE		3. POSITION		4. DEPARTMENT		5. OFFICE		6. CITY		7. STATE		8. ZIP	
9. SOCIAL SECURITY NUMBER		10. DATE OF BIRTH		11. SEX		12. RACE		13. RELIGION		14. MARRIAGE STATUS		15. NUMBER OF CHILDREN		16. EDUCATION	
17. EMPLOYMENT HISTORY		18. REASON FOR LEAVING		19. REFERENCES		20. COMMENTS		21. SIGNATURE		22. DATE		23. EMPLOYER'S SIGNATURE		24. EMPLOYER'S DATE	
25. EMPLOYER'S ADDRESS		26. EMPLOYER'S PHONE		27. EMPLOYER'S FAX		28. EMPLOYER'S E-MAIL		29. EMPLOYER'S WEBSITE		30. EMPLOYER'S URL		31. EMPLOYER'S URL		32. EMPLOYER'S URL	

THIS FORM IS TO BE FILLED OUT BY THE EMPLOYEE AND SUBMITTED TO THE EMPLOYER'S OFFICE. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM. THE EMPLOYEE'S SIGNATURE AND DATE ARE REQUIRED FOR THIS FORM TO BE VALID. THE EMPLOYER'S SIGNATURE AND DATE ARE ALSO REQUIRED. THIS FORM IS TO BE KEPT ON FILE IN THE EMPLOYEE'S PERSONNEL FILE.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01689

CERTIFICATE OF DEATH

01686

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1210 Sterling Circle</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Louis</b> Last <b>NORTON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1901</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN L. NORTON</b>		14. MOTHER'S MAIDEN NAME <b>? GALT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MAUDE B. NORTON # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621 Bronchogenic Carcinoma</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>8/16, 1966</b> , to <b>Feb. 2, 1967</b> , that (I) <b>204</b> last saw the deceased alive on <b>Feb. 22, 1967</b> , and that death occurred at <b>12:20 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.		22b. DATE SIGNED <b>2/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-4-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST MEM. CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS AA.G. MD</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01690					01687				
1. PLACE OF DEATH a. COUNTY <u>A-A</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			c. LENGTH OF STAY IN 1b <u>102-1</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park 21146</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR Nursing Home</u>					d. STREET ADDRESS <u>101 Linda Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELSIE J.</u>			First Middle Last		4. DATE OF DEATH <u>2-8-67</u>		Month Day Year <u>19</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 23, 1884</u>		9. AGE (In years) <u>82</u> (last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Bartholomew</u>					14. MOTHER'S MAIDEN NAME <u>Sybilla Dietz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-54-9746J1</u>		17. INFORMANT Address <u>Mrs. Julia O. Saunders</u> (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>myocardial infarction</u> <u>420.1</u> DUE TO (b) <u>C.E.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sen art</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>  </u> , to <u>1967</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2-1-67</u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert R. Hahn</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>						22d. ADDRESS <u>P.O. Box 73 Severna Park</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						25a. REC'D BY REGISTRAR <u>Feb 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>P.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>ANCO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ridge Road</i>		d. STREET ADDRESS <i>Ridge Road</i>	
3. NAME OF DECEASED (Type or print) <i>Harold E. Peterson</i>		4. DATE OF DEATH Month <i>✓</i> Day <i>9</i> Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/2/1938</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	9. AGE (In years last birthday) <i>28</i> 17/11/28 yrs.
11. BIRTHPLACE (State or foreign country) <i>Florida</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Gordon Peterson</i>		14. MOTHER'S MAIDEN NAME <i>Jackson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes 1956-1964</i>		16. SOCIAL SECURITY NO. <i>472347315</i>	
17. INFORMANT <i>Mrs. Edith A. Peterson - Same</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot wound Skull</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self inflicted gun shot wound</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>6:30</i> p.m. <i>1967</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>ANCO MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i> EXAMINER'S NAME (Type) <i>E. Linhardt</i>		22. DATE SIGNED <i>2/9/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/13/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Natl Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Balto. Maryland</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. 5305 Harford Rd.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 14 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE HEALTH DEPT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

53

MEDICAL CERTIFICATION

BP

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01692

CERTIFICATE OF DEATH

01689

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>				d. STREET ADDRESS <b>3 Riverview Ave., Weems Creek</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nick</b> Middle <b>Joseph</b> Last <b>POCHATKO</b>				4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-1905</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAINTING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NANTICOKE, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ELIAS POCHATKO</b>				14. MOTHER'S MAIDEN NAME <b>ANNA STRELLA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>THOMAS POCHATKO</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extreme Cachexia + malnourishment</b> DUE TO (b) <b>Obstruction oral cavity</b> DUE TO (c) <b>Squamous cell Carcinoma oral cavity</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Note point of origin of Carcinoma unknown</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>was not present</del> attended the deceased from <b>2-15</b> , 19 <b>67</b> , to <b>Feb. 22</b> , 19 <b>67</b> , that (I) <del>was not</del> last saw the deceased alive on <b>Feb. 22</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Peter F. Verkouw</b>				ATTENDING PHYS. <b>XX</b> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter F. Verkouw, M.D.</b>				22d. ADDRESS <b>1407 Forest Drive, Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City or town) (County) (State) <b>ANNAPOIS MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Latta &amp; Sons</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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James Hamilton

Hamilton

James Hamilton

Annals

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RURAL - Annals

James Hamilton General Hospital

7 River View Ave., James Creek

John

Joseph

FOOTLOCK

February

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White

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Painting

Painter

ELIAS FOOTLOCK

Anna Stella

THOMAS FOOTLOCK

#2

FOOTLOCK, Pennsylvania

11-1-1905

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Feb. 25, 1905

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Feb. 25, 1905

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JACK - Green Drive, Annals, N.C.

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Annals

St Marys

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01693

CERTIFICATE OF DEATH

01690

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		d. STREET ADDRESS <u>104 CLAUDE ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 CLAUDE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE BEATRICE REHN</u>		4. DATE OF DEATH <u>FEB. 12, 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERICAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNE ARUNDEL, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE ROBERT MITCHELL</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN ALEXANDER HALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-14-3573</u>	
17. INFORMANT <u>Alvin E. Reddy, Jr.</u>		Address <u>Same as #2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTASES</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF SIGMOID COLON</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC.</u> , 19 <u>63</u> to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>9 A.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Jesse L. Wilkins</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS</u>		22d. ADDRESS <u>98 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.A. Md.</u>	
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> <u>HOPPING FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 16 1967</u>	

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STATE OF MICHIGAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01694

01691

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>30 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.A. NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>24 BOXWOOD RD. ANNA. MD.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY KENNETH RICHARDSON</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 5 1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>20 NOV. 1901</b>	
9. AGE (in years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTH PLACE (County & State, or foreign country) <b>SANTA BARBARA, CALIF.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MASTER AT ARMS NAVAL ACAD. CIVIL SERVICE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>UNK.</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>1939-1945</b>			
17. INFORMANT <b>ELSIE MARIE RICHARDSON #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of AORTIC ANEURYSM</b> <b>451X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) <b>hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Obstructive Emphysema</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>5 FEB</b> , 1967, to <b>5 FEB</b> , 1967, that (I) <b>did</b> last saw the deceased alive on <b>5 FEB</b> , 1967, and that death occurred at <b>5:21 M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Roger M. F. Smith</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>FEB 5, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Roger M. F. SMITH, LT MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-8-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLen HAVEN</b>	
23d. LOCATION (City, town or county) (State) <b>MD.</b>				23e. REGISTRAR'S SIGNATURE <b>Charles J...</b>			
24. FUNERAL DIRECTOR <b>John M. Lyons</b>				ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1967</b>	

for 11 to 12 hours (unusual), Mrs.  
Glen Haven 2-8-17  
Glen Haven

Glen Haven

MD

1942-1947 214-47-27416 Marie Richardson #2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01695

CERTIFICATE OF DEATH

01692

1. PLACE OF DEATH a. COUNTY <b>Annapolis</b> <b>A.A. Co.</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>33 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>Loretta Heights</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>(none)</b> Last <b>RIGGINS</b>			4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1886</b>		9. AGE (In years last birthday) yrs. <b>80</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>JOSEPH DAVIDSON</b>			14. MOTHER'S MAIDEN NAME <b>DAVIS</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>WALTER W. RIGGINS #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Stroke</b> <b>yes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Jan. 10,</b> 19 <b>67</b> , to <b>Feb. 12,</b> 19 <b>67</b> , that (I) <del>we</del> last saw the deceased alive on <b>Feb. 12,</b> 19 <b>67</b> , and that death occurred at <b>3:55 PM</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Granville Shipley</b>			22b. DATE SIGNED <b>2-13-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>GRANVILLE SHIPLEY</b>			22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-15-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD.</b>		
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR Son ANNAPOLIS MD</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 14 1967</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01686

CERTIFICATE OF DEATH

01693

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>146 O'bervy Court</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Robinson, Jr.</b>		4. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1951</b>
9. AGE (In years lost birthday) <b>15</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Robinson, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Standola Wright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John H. Robinson, Sr.</b>		Address <b>146 O'bervy Ct. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>66</b> , to <b>2/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/7</b> , 19 <b>67</b> , and that death occurred at <b>6:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M. D.</b>		22b. DATE SIGNED <b>2/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A. Md</b>
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111</b>		25a. REC'D BY REGISTRAR <b>Annopolis, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 14 1967</b>	

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## Discussion

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01697					01694						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Anne Arundel</u>					a. STATE <u>Maryland</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					b. COUNTY <u>Anne Arundel</u>						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>					d. STREET ADDRESS <u>1220 McKinley Street</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<u>LEWIS LAMBDIN ROBINSON</u>			<u>February</u>			<u>11 1967</u>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Male</u>		<u>Cauc</u>		<u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<u>27 January 1909</u>		<u>58</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Oscar Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Lambdin</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII - Korea</u>				16. SOCIAL SECURITY NO. <u>219-34-6716</u>		17. INFORMANT <u>Mrs. E.M. Robinson</u>		Address <u>1220 McKinley St. Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11 Feb</u> , 19 <u>67</u> , to <u>11 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11 February 1967</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Barry John Coughlin</u>								22b. DATE SIGNED <u>11 Feb. 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Barry John Coughlin</u>								22d. ADDRESS <u>Naval Hospital, Annapolis, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>					
24. FUNERAL DIRECTOR <u>John M. Layton &amp; Sons Annapolis, Md.</u>						25a. REC'D BY REGISTRAR <u>DATE FEB 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01698

## CERTIFICATE OF DEATH

01695

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>30-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN 1b <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>4213 Mary Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33332 <b>Albert A. Ronspies</b>				4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11/15/ 1900</b>		9. AGE (In years lost birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bromo Seltzer Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Bromo Seltzer Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Albert Ronspies</b>				14. MOTHER'S MAIDEN NAME <b>Anna Taylor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>217-22-6113</b>		17. INFORMANT <b>Hospital Records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416X</b> <b>Confluent Bronchopneumonia, Bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>6021</b> (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>Old Myocardial Infarct; TBC-Right Lung, Inanition</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Myocardial Infarct; TBC-Right Lung, Inanition</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12</b> p.m. <b>12</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>9/19/ 19 66</b> to <b>2/17/ 19 67</b> , that (I) (we) lost the deceased alive on <b>2/17/ 19 67</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>L. Benedict</b>				A. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/21/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>FEB 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. *Introduction*

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01699

## CERTIFICATE OF DEATH

01696

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN TB <u>2 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				d. STREET ADDRESS <u>Rt. 2 Bahama Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Michele S. Scarlett</u>				4. DATE OF DEATH Month Day Year <u>2 20 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-67</u>	9. AGE (In years lost birthday) yrs. <u>24</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. <u>1 1/2 days</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Bruce Scarlett</u>				14. MOTHER'S MAIDEN NAME <u>Darlene Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother's chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> <u>773.5</u> DUE TO <u>(cystic membrane)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <u>Premature</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/17/67</u> , 19 <u>67</u> , to <u>2/20/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/20/67</u> , 19 <u>67</u> , and that death occurred at <u>3A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>S. Munsters</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Silvino B. Munsters</u>				22d. ADDRESS <u>5004 Ritchie Hwy</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2 21 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, A. A. Co. Md</u>	
24. FUNERAL DIRECTOR <u>Mc Cully</u>				ADDRESS <u>130 E. Port Ave</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01700

CERTIFICATE OF DEATH

01697

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>43 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 Ferdinand Ave.</u>		d. STREET ADDRESS <u>8 Ferdinand Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MARIE</u>		4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Suffer</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-7056-B</u>	
17. INFORMANT <u>John C. Schaeffer (Husband)</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>331X</u> DUE TO <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>Feb. 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 19</u> , 19 <u>67</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ignas Saulynas</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Ignas Saulynas, M.D.</u>		22d. ADDRESS <u>319 Old Annapolis Rd. Ferndale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>  </u>	

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CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01701					01698				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
e. COUNTY ANNE ARUNDEL MARYLAND					e. STATE OHIO b. COUNTY JEFFERSON				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort George G. Meade, Md.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mingo Junction				
c. LENGTH OF STAY IN 1b 17 days					d. STREET ADDRESS 316 Carlisle Ave				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kimbrough AH Ft Geo g Meade, Md.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) PAUL ALLEN SCHAYES					4. DATE OF DEATH February 2 1967				
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 December 1945		9. AGE (In years last birthday) yrs. 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (County & State, or foreign country) Jefferson, Ohio		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Ernest Theodore Schayes					14. MOTHER'S MAIDEN NAME Pearl Imogene Malone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1965-1967		17. INFORMANT Ernest Schayes (F)		316 Carlisle Ave Mingo Junction, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Rheumatic Pancarditis									
4013 DUE TO (b) Acute Recurrent Rheumatic Fever									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour s.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 16 Jan 67, 1967, to 2 Feb 1967, and that death occurred at 9:45 AM from the causes and on the date stated above.									
22a. SIGNATURE Lynn W. Holder, M.D.					22b. DATE 2 February 1967				
22c. PHYSICIAN'S NAME (Type) LYNN W. HOLDER, CPT, MC					22d. ADDRESS KIMBROUGH AH, FT GEO G. MEADE, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Steuben Cemetery		23d. LOCATION (City, town or county) (State) Steubenville, Ohio			
24. FUNERAL DIRECTOR'S SIGNATURE Charles Judge					25a. REC'D BY REGISTRAR DATE FEB 8 1967				
25b. REGISTRAR'S SIGNATURE Charles Judge									

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01702

CERTIFICATE OF DEATH

01699

1. PLACE OF DEATH a. COUNTY <b>Anna Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1206 West St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Henry</b> Last <b>SCIBLE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>02</b> Days <b>1</b> Hours <b>1</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>District Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INS Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Taylor Scible</b>		14. MOTHER'S MAIDEN NAME <b>Emma Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Nettie S. Carr #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of esophagus with</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cerebral metastases</b> DUE TO (c) <b>2 mm</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>2</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this doctor) attended the deceased from <b>Feb. 19 1967</b> , to <b>Feb. 19 1967</b> that (I) <b>yes</b> saw the deceased alive on <b>Feb. 19 1967</b> , and that death occurred at <b>7:15 AM</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Preher</b>		22b. DATE SIGNED <b>2-20-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD I. PREHER</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BUFF</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis H.A. Md.</b>
24. FUNERAL DIRECTOR <b>John M. Lyles &amp; Sons Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01302

STANDARD

01302

Anne Arundel County Hospital

Annexed

1888

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Dec. 5, 1888

U.S.

U.S.

U.S.

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1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01703 CERTIFICATE OF DEATH 01700

1. PLACE OF DEATH a. COUNTY <u>A-A-G</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u> c. LENGTH OF STAY IN 1b <u>11 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>20 HATTON DR.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A-A</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u> d. STREET ADDRESS <u>20 HATTON Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SOPHIE M. SHEATS</u>				4. DATE OF DEATH <u>2-2-1967</u>			
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-83</u>	
9. AGE (In years last birthday) <u>83 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife @ home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OTTO WIESENBACH</u>				14. MOTHER'S MAIDEN NAME <u>MARY WEBER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Feloy Sheets</u> Address <u>Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> , 19 <u>52</u> , to <u>Feb 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>February 1</u> , 19 <u>67</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Newland E. Day</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>February 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEWLAND E DAY</u>				22d. ADDRESS <u>4-E-33rd St Ball</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fondren Park</u>		23d. LOCATION (City, town or county) (State) <u>Balt MD</u>	
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u> ADDRESS <u>Severna Park, Md</u>				25a. REC'D BY REGISTRAR <u>Robert S. Barranco</u> DATE <u>FEB 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

01703

01703

Handwritten notes and stamps, including "HATTON" and "2 HEADS".

Refund of amount (unclear)  
A300D

Handwritten notes and stamps, including "4-6-33-24 Box", "Mentone E. Day", and "25 Feb 34".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01704

CERTIFICATE OF DEATH

01701

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>				d. STREET ADDRESS <b>108 Dension Drive</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Gary</b> Last <b>Shifflett</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1952</b>	9. AGE (In years last birthday) <b>14</b> yrs.	IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.		IF UNDER 24 HRS. Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert M. Shifflett</b>				14. MOTHER'S MAIDEN NAME <b>Josie B. Sullivan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MR. ALBERT M. Shifflett (Father) as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pulmonary edema</b> DUE TO (c) <b>Essential hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>days</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congenital heart disease</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/10, 1967</b> to <b>2/14, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/14, 1967</b> , and that death occurred at <b>9:24 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Max C Frank</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MAX C FRANK</b>				22d. ADDRESS <b>425 SE RITCHIE Hwy Glen Burnie</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillsboro Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>CROZET, Virginia</b>	
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>				25a. REC'D BY REGISTRAR <b>Glen Burnie</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01701  
01702

01701

Joseph B. Sullivan

School

Mr. Albert M. Shiplett (father) 2000

Home

Project Virginia

Willsboro Center

Feb 18 1968

Richard N. Singleton Glen Burnie Md



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01705

CERTIFICATE OF DEATH

01702

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. MARGARETS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H.A. GENERAL Hospt. D.O.A.</u>		d. STREET ADDRESS <u>R.F.D. Box 283</u>	
3. NAME OF DECEASED (Type or print) <u>BERTHA</u> First <u>SMITH</u> Middle <u>SMITH</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WARSAW POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL KUCINSKI</u>		14. MOTHER'S MAIDEN NAME <u>  </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>MARYL WINDSOR</u> Address <u>#2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis?</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes M</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>08</u> , 19 <u>66</u> , to <u>2-25</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-19-67</u> , and that death occurred at <u>1230</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>F.M. Shipley</u>		22b. DATE SIGNED <u>2-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.M. SHIPLEY</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. STANISLAUS</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Lyle &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 28 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED  
FEB 28 1981  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

0110

0110

St. Margaret's  
R.F.D. Box 283

A.A. General Hosp. D.O.F.  
Annapolis, Md.

22 17

Bertha

8-28-1841  
Wasson Island

W

Home  
Paul Kinski  
Huswife

Meryl Winsor #2

W.S.A.

St. Stanislaus  
Annapolis, Md.  
8-28-47

Bkto.

MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01706

CERTIFICATE OF DEATH

01703

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Vernie</u> First <u>Smith</u> Middle <u>—</u> Last <u>—</u>		4. DATE OF DEATH <u>Feb</u> Month <u>14</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2, 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Julie Howard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Nellie Brice, Bristol Md.</u> Address <u>—</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>No Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>Nov</u> , 19 <u>66</u> , to <u>Feb</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Feb</u> , 19 <u>67</u> , and that death occurred at <u>10:45 P.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Wirth, M.D.</u>		22b. DATE SIGNED <u>Feb 14, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Wirth, M.D.</u>		22d. ADDRESS <u>Lothian, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-18-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		23d. LOCATION (City or Town) (County) (State) <u>Wicomico</u>	
24. FUNERAL DIRECTOR <u>William Beasly</u>		25. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	
25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 15 1967</u>		DATE <u>FEB 15 1967</u>	

01569

20510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

01707

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01704

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 10 da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Box-257S</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roland</b> Middle <b>Thomas</b> Last <b>SOMERS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1901</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUILDER-CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CALWOOD S. SOMERS</b>				14. MOTHER'S MAIDEN NAME <b>MOLLIE DUNCAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>BLANCHE BOZMAN SOMERS #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema, car pulmonale with failure</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>1964</b> to <b>Feb. 3</b> , 19 <b>67</b> that (I) <del>we</del> lost saw the deceased alive on <b>Feb. 3</b> , 19 <b>67</b> , and that death occurred at <b>7:50 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b>				ATTENDING MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-4-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER</b>				22d. ADDRESS <b>121 CATHOEDRAL ST. ANNAPOLIS MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-6-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>EASTON MD</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR-SONS ANNAPOLIS MD</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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Builder-Contractor Construction District Co.

Carwood S. Somers

Morris Duncan

Branch Bowman Somers #2

x

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2-4-1917

121 Catonsville St. Annapolis Md.

Richard M. Peeler

Md

Easton

2-6-1917 Spring Hill Cem

Burial

John M. Taylor - 2nd Annapolis Md



MAR 16 1967

FOR STATE  
HEALTH DEPT.

01708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01705

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General</b>				d. STREET ADDRESS <b>16 East Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>No</b> Last <b>SPRINGFIELD</b>				4. DATE Pronounced <b>February 25, 1967</b> OF DEATH			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-1900</b>		9. AGE (In years lost birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CITY FIRE Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>BENEDICT, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. A. Springfield</b>				14. MOTHER'S MAIDEN NAME <b>Annie Laurie Constance</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>FRANCES Springfield #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in water, presumably drowned</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Unknown 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) (County) (State) <b>Annapolis A A Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D. <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>February 26, 1967</b>	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State) <b>BURIAL 2-28-67 ST. ANNES ANNAPOLIS A.A. MD.</b>	
24. GENERAL DIRECTOR ADDRESS <b>John M. Lyons Sons Annapolis, Md</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 10 1957

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3-21-1950

Mr

Ret.  
 George W. A. Springfield  
 Frances Springfield #2  
 Annie Laurie Constance  
 City Fire Dept. Benedict, Md.  
 U.S.

3-28-57 24 Hours  
 Springfield, Mo

Springfield, Mo  
 FEB 27 1957

AA MO

1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5 S. RITCHIE HWY</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> d. STREET ADDRESS <u>5 S. RITCHIE HWY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>RUTH ANN STEWART</u> First Middle Last <b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10-28-11</u> <b>9. AGE</b> (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>						<b>4. DATE OF DEATH</b> <u>2-6-67</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RESTAURANT</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>NORTH CAROLINA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>EDWARDS</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>530141571</u> <b>17. INFORMANT</b> <u>Ephraim STEWART (HUSBAND)</u> Address <u>ABOVE</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>Chronic bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Coronary Artery Disease</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Pasadena</u> (County) <u>A.A.</u> (State) <u>MD</u>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>[Signature]</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>E. Linhart</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2-5-67</u>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>2-6-67</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MEADOWRIDGE CEM.</u>		<b>22d. LOCATION</b> (City, town, or county) <u>DORSEY</u> (State) <u>MD</u>			
<b>23. FUNERAL DIRECTOR</b> <u>Robert S. Barranco</u> ADDRESS <u>Severna Park, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> DATE <u>FEB 7 1967</u>					

ROBERT S. BARRANCO



20 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01710

01707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Austin</u> Last <u>STUART</u>		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 11, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. M.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	9. AGE (In years last birthday) <u>67</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>SPOKANE, WASHINGTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Willey Stuart</u>		14. MOTHER'S MAIDEN NAME <u>Effie LaRue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-44-6649</u>	
17. INFORMANT <u>Sally Cross Stuart</u>		Address <u>Edgewater, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u> DUE TO (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-8</u> , 1967, to <u>2-8</u> , 1967, that (I) (we) just saw the deceased alive on <u>2-8</u> 1967, and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Emily H. Wilson</u>		22b. DATE SIGNED <u>2-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Emily H. Wilson, M.D.</u>		22d. ADDRESS <u>Lothian, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Feb 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U.S. Naval Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis, Md</u>
24. FUNERAL DIRECTOR <u>TA Hardisty</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
ADDRESS <u>12 Ridgely Ave Annapolis, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01711

CERTIFICATE OF DEATH

01708

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Thomas</b> Last <b>TAPP</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1902</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Culpepper, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE E. TAPP</b>		14. MOTHER'S M maiden name <b>ALLMIRE C. BROWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>IRENE Tapp # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the prostate</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>physician</del> attended the deceased from <b>Dec. 20, 19 66</b> , to <b>Feb. 1, 19 67</b> , that (I) <del>we</del> last saw the deceased alive on <b>Feb. 1, 19 67</b> , and that death occurred at <b>—</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin Davis, Jr.</b>		22b. DATE SIGNED <b>2/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr. M.D.</b>		22d. ADDRESS <b>100 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-4-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION (City or town) (County) (State) <b>Annapolis A.A. MD.</b>	
24. FUNERAL DIRECTOR <b>Donald S. Lg La Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. C. ...</b>			

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George E. Tapp  
Farmer  
Culpepper, Virginia

George E. Tapp  
Farmer  
Culpepper, Virginia

George E. Tapp #2

one hundred

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George E. Tapp #2

George E. Tapp #2

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01712

CERTIFICATE OF DEATH

01709

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>188 Duke of Gloucester St.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Arvilla</b> Middle <b>Sommers</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 4, 1890</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland =</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>ROBERT SOMMERS</b>				14. MOTHER'S MAIDEN NAME <b>Arvilla Wehls</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 36 3035 B</b>		17. INFORMANT <b>D. S. TAYLOR #2</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis?</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Anticoagulative CVD</b> DUE TO (c) <b>Marked obesity.</b>						INTERVAL BETWEEN DEATH AND DEATH <b>0.0.0.</b> <b>yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Feb</b> , 1966, to <b>2-24, 1967</b> that (I) <b>yes</b> last saw the deceased alive on <b>2-24</b> 19 <b>67</b> and that death occurred at <b>10:00 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>F. M. S. H. / P. L. E. X</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. M. S. H. / P. L. E. X</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>BURIAL</b>		<b>2-24-67</b>		<b>ST. ANNES</b>		<b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor Sons Annapolis, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01110

CHURCH OF DEATH

01110

Anna Arnold

Anna Arnold

Anna Arnold

Anna Arnold

Anna Arnold

108 Lake of Geneva St.,

Anna Arnold, General Hospital  
(Dead on Arrival)

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Robert Sommers  
Arville Wells

no 22 Taylor #2

10:00 PM

21

121 Cathedral St., Annapolis, Md.

Annapolis

St. Annes

2-24-67

St. Annes Episcopal Church, Md.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01710											
1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>B.A. CO.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold ANNAPOLIS</u>						c. LENGTH OF STAY in 1b <u>DOH</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>O.O.A. - Anne Arundel General</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>					
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>E.</u> Last <u>Taylor</u>						4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-19-59</u>		9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Second Grade</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward E. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Paul</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Edward E. Taylor</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9298 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>True blue ice support, Annie</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>2:12</u> 19 <u>67</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woodsman Lane</u>		20f. (City or town) <u>ARCO</u>		(County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. Linhart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>2/12/67</u>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-15-67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodsman Cem</u>		22d. LOCATION (City, town, or county) <u>Woodsman Balto, MD</u>		22e. REC'D BY REGISTRAR <u>Robert S. Barranco</u>		22f. REGISTRAR'S SIGNATURE <u>Robert S. Barranco</u>	
23. FUNERAL DIRECTOR <u>Robert S. Barranco</u>						ADDRESS <u>Severna Park, MD</u>					
DATE <u>FEB 15 1967</u>						J. Charles Judge					

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DAVID

DAVID

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*[Faint, illegible handwriting]*

*[Faint, illegible handwriting]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01714

01711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt. 5, Box 76</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Joseph</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 16, 1903</b>		9. AGE (In years lost birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months <b>02</b> Days <b>10</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John R. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Carne Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Maggie Thomas Anna Md</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate</b> 1978 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that death occurred at _____ M. from causes and on the date stated above.							
22a. SIGNATURE <b>Theodore G. Osius</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>February 11, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Theodore G. Osius M. D.</b>				22d. ADDRESS <b>77 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-14-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		23d. LOCATION (City or Town) (County) (State) <b>St. Margaret Md</b>	
24. FUNERAL DIRECTOR <b>William Reese Jr</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>FEB 14 1967</b>							

0111

DEATH CERTIFICATE

0111

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE: [illegible]

REPORTED BY: [illegible]

X

DECEASED IN: [illegible]

DATE: [illegible]

REPORTED BY: [illegible]

DATE: [illegible]

REPORTED BY: [illegible]

DECEASED IN: [illegible]

DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01715

01712

1. PLACE OF DEATH a. COUNTY <u>Anne-Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing and Convalescent Center</u>		d. STREET ADDRESS <u>622 Catar Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JANE C. VEDITZ</u>		4. DATE OF DEATH <u>Feb. 19</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary Brokerage</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles H Veditz</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Aspin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>212-22-6344</u>	
17. INFORMANT <u>Mr. Robert Bouchelle</u>		Address <u>509 W. Pratt St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Per Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>66</u> , to <u>Feb.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> 19 <u>67</u> , and that death occurred at <u>4 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John A. Moran</u>		22b. DATE SIGNED <u>2/19/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/23/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John A. Moran Inc. 3000 E. Baltimore Street</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

01715

111115

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01716

CERTIFICATE OF DEATH

01713

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			c. LENGTH OF STAY IN 1b <b>9 yrs. 2 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center Hospital</b>				d. STREET ADDRESS <b>Our Lady of Mercy School</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Alberta</b> Middle <b>Virostek</b> Last <b>7</b>				4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/14/36</b>		
9. AGE (In years lost birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Farrell, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Andrew Virostek</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Bernadetta (Tobasco)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Children's Center Hospital, Laurel, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of food</b> <b>325.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mental retardation</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1</b> , 19 <b>57</b> , to <b>Feb. 7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb. 7</b> , 19 <b>67</b> , and that death occurred at <b>9:05am</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>George T. Economos</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/7/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>GEORGE T. ECONOMOS, M. D.</b>				22d. ADDRESS <b>Children's Center Hospital, Laurel, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-9-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring, Md.</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <b>Joe Gawler's Sons Inc.</b>				25a. REC'D BY REGISTRAR <b>5130 Wisconsin Ave. N.W. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01710

01710

Form with multiple sections and fields, including a large central box and various labels. The text is mirrored and appears to be bleed-through from the reverse side of the page.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01717

01714

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>7 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glenn Mann Funeral Home, 1015 7th St, 730 Margate Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>730 Margate Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Robert</u> Middle <u>E</u> Last <u>Walker</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>21</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>3-23-1891</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.                 IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unknown (Ret)</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self-Emp -</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Tennessee</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. America</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>409-09-496</u>		<b>17. INFORMANT</b> Address <u>Drusilla Newport (Daughter)</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Pulmonary Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Residual Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>Baltimore</u>		<b>20g. (County)</b> <u>Maryland</u>		<b>20h. (State)</b> <u>Maryland</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/18</u> <b>19</b> <u>67</u> <b>to</b> <u>2/21</u> <b>19</b> <u>67</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/18</u> <b>19</b> <u>67</u> <b>and that death occurred at</b> <u>2 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Richard H. Hunt</u>				<b>22b. DATE SIGNED</b> <u>Feb 21, 1967</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Richard H. Hunt</u>				<b>22d. ADDRESS</b> <u>100 Cherry Lane, Glen Burnie, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/25/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lorraine Park Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>BALTO</u>		<b>23e. (State)</b> <u>MARYLAND</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert Kugler</u>			
<b>24a. ADDRESS</b> <u>Singleton Funeral Home, Glen Burnie, Md</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 24 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
20 M 1/66

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01718

CERTIFICATE OF DEATH

01715

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>WHITE HOUSE ROAD</b>			
3. NAME OF DECEASED (Type or print) <b>ROBERT F. WALSTON, Sr.</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>13</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>27 JAN 1909</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USNAVALACAD</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US GOVT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FAIRMOUNT, MARYLAND</b>	
13. FATHER'S NAME <b>Robert Hays Walston</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Laura R. Walston #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 VENTRICULAR FIBRILLATION</b> DUE TO (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HOUR</b> <b>2 HOURS</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>HYPERTENSION, UNCONTROLLED DIABETES, OBESITY</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>FEB 13, 1967</b> , to <b>FEB 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>FEB 13, 1967</b> , and that death occurred at <b>10P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Charles W. Kinzer</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>13 FEB 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES W. KINZER, M.D.</b>				22d. ADDRESS <b>SOUTH RIVER MEDICAL CENTER EDGEWATER, MARYLAND 21037</b>			
23a. BURIAL, CREMATION, REMOVAL Specify	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
<b>BURIAL</b>	<b>2-16-1967</b>	<b>Edwards Chapel</b>		<b>Annapolis</b>		<b>MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Saylor + Sons Annapolis, Md.</b>				25. REC'D BY REGISTRAR <b>FEB 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

01110

01110

01110

Robert Hays Walston

Addie May Hutley

Laura R. Walston #2

No

2-11-1917 Edward Chapel Annapolis Md  
John H. Taylor & Son Annapolis Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01719					01716				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND					a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>NINE MONTHS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. NAVAL HOSPITAL</u>					d. STREET ADDRESS <u>8 SOUTH HAVEN ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First <u>BRENDA</u>		Middle <u>SUE</u>		Last <u>WALTER</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>4</u> Year <u>19 67</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 MARCH 1965</u>		9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHINA LAKE, CALIFORNIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BARRY LEE WALTER</u>					14. MOTHER'S MAIDEN NAME <u>PATRICIA IRENE FERGUSON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT <u>BARRY LEE WALTER, 8 SOUTH HAVEN ROAD, ANNA, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>7542</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>CONGENITAL HEART DISEASE (VSD)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4 FEB</u> , 19 <u>67</u> , to <u>4 FEB</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4 FEB</u> 19 <u>67</u> , and that death occurred at <u>1:50M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles L. Gaudry</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4 FEBRUARY 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>CHARLES L. GAUDRY</u>					22d. ADDRESS <u>122 WEST 5th</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD</u>		
24. FUNERAL DIRECTOR <u>BEALL FUNERAL HOME</u>					ADDRESS <u>122 WEST 5th</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

01510

Robert L. Smith



CERTIFICATE OF DEATH

Reg. Dist. No. 01717

01720

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Knollwood manor n/Home</u>				d. STREET ADDRESS <u>217 Meadow Road</u>			
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>A.</u> Middle <u>WATTS</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 Oct. 1877</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>27</u> Days <u>19</u> Hours <u>67</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Aid</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Albert Tunstall</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Betts</u>				15. DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>013-24-6050A</u>				17. INFORMANT Address <u>Albert E. Jones (son) Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>10 YRS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>APRIL, 1962</u> to <u>2/27</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>67</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city or town, state) <u>8471 Ft. Smallwood Road</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				DATE SIGNED <u>2/27/67</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3 MARCH 67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOPE Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester MASS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware</u> ADDRESS <u>Singleton Funeral Home / Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

01770

01770

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF BIRTH <i>Jan 1, 1900</i></p>	
<p>RESIDENCE <i>123 Main St, Baltimore, Md</i></p>		<p>DATE OF DEATH <i>Jan 15, 1950</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>SEX <i>Male</i></p>		<p>AGE <i>50</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RELIGION <i>Catholic</i></p>		<p>DATE OF MARRIAGE <i>Jan 1, 1920</i></p>	
<p>NAME OF SPOUSE <i>Jane Doe</i></p>		<p>DATE OF DEATH OF SPOUSE <i>None</i></p>	
<p>NAME OF CHILDREN <i>John Jr, Mary, Robert</i></p>		<p>DATE OF DEATH OF CHILDREN <i>None</i></p>	
<p>NAME OF NEXT OF KIN <i>John Doe</i></p>		<p>DATE OF DEATH OF NEXT OF KIN <i>None</i></p>	
<p>NAME OF PHYSICIAN <i>Dr. John Smith</i></p>		<p>DATE OF DEATH OF PHYSICIAN <i>None</i></p>	
<p>NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i></p>		<p>DATE OF BURIAL <i>Jan 17, 1950</i></p>	
<p>NAME OF FUNERAL HOME <i>John Doe &amp; Sons</i></p>		<p>DATE OF FUNERAL <i>Jan 16, 1950</i></p>	
<p>NAME OF MINISTER <i>Rev. John Doe</i></p>		<p>DATE OF DEATH OF MINISTER <i>None</i></p>	
<p>NAME OF CHURCH <i>St. Mary's Church</i></p>		<p>DATE OF DEATH OF CHURCH <i>None</i></p>	
<p>NAME OF CEMETERY <i>St. Mary's Cemetery</i></p>		<p>DATE OF DEATH OF CEMETERY <i>None</i></p>	
<p>NAME OF INTERVIEWER <i>John Doe</i></p>		<p>DATE OF INTERVIEW <i>Jan 15, 1950</i></p>	
<p>NAME OF WITNESS <i>John Doe</i></p>		<p>DATE OF DEATH OF WITNESS <i>None</i></p>	
<p>NAME OF SIGNER <i>John Doe</i></p>		<p>DATE OF DEATH OF SIGNER <i>None</i></p>	

3

1M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01721

CERTIFICATE OF DEATH

01718

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALT. CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROUNSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1/26/67</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CROUNSVILLE STATE HOSPITAL</b>		d. STREET ADDRESS <b>36 S. FREMONT AVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>NEEKS</b> Last <b>NEEKS</b>		4. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/96</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>11</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>3</b> <b>Architect</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>2</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MANASSAS, VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANKLIN NEEKS</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE CRAMBLETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>!</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>BRONCHO PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>7/26/67</b> , 19__, to <b>2/11/67</b> , 19__, that <b>(X)</b> (we) last saw the deceased alive on <b>2/11/67</b> , 19__, and that death occurred at <b>5:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Benedict M.D.</b>		22b. DATE SIGNED <b>2/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-14-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City or Town) (County) (State) <b>MD</b>	
24. FUNERAL DIRECTOR <b>Shelma A. Hoffmann</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 16 1967</b>	

01710

CERTIFICATE OF DEATH

01710

W. 1000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01722

01719

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>25 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Box-25</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Chesterfield</b> Middle <b>WHITE</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1892</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>George White</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Booye</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-078905</b>		17. INFORMANT <b>Christina White, Galesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the esophagus</b> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>6 months or more</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>physician</b> attended the deceased from <b>Dec 1</b> , 19 <b>66</b> , to <b>Feb. 2</b> , 19 <b>67</b> , that (I) <b>had</b> last saw the deceased alive on <b>Feb. 2</b> , 19 <b>67</b> , and that death occurred at <b>9:00 PM</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Willard F. Smith</b>				ATTENDING MED. PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Willard F. Smith, M.D.</b>				22d. ADDRESS <b>Shady Side, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-7-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>		23d. LOCATION (City or Town) (County) (State) <b>Galesville Md.</b>	
24. FUNERAL DIRECTOR <b>William Reese Jr. Annapolis, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

01720

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 4 month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>#30608 Laura Dean Wise</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1884</u>
9. AGE (In years last birthday) <u>82 82 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calub Dean</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome sec. to Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/29/1965</u> , to <u>2/27/1967</u> , that (I) (we) last saw the deceased alive on <u>2/27/1967</u> , and that death occurred at <u>6:00 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>2/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Joy Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>St. Mary's Co.-Maryland</u>
24. FUNERAL DIRECTOR <u>Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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ESS 10

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01724

01721

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie-rural</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>				d. STREET ADDRESS <b>313 17th Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>W.</b> Last <b>Wood</b>				4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/52</b>	9. AGE (In years lost birthday) <b>14</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jack M Wood</b>				14. MOTHER'S MAIDEN NAME <b>Vivian Pupert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning associated with smoke</b> <b>9160</b> <b>and soot inhalation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2:00</b> <b>xx</b> <b>2</b> <b>18</b> <b>19</b> <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>shack</b>		20f. (City or town) (County) (State) <b>Brooklyn Pk. A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>2/19/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie AA CO Md</b>	
24. FUNERAL DIRECTOR <b>McOully F H 237 Patapsco Ave 21225</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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